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Pepperdine University  
Graduate School of Education and Psychology

A QUALITATIVE ANALYSIS OF CLIENT EXPRESSIONS OF MEANING IN  
PSYCHOTHERAPY

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Alexander Michael Bacher

November, 2009

Susan Hall, J.D., Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Alexander Michael Bacher

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

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## DEDICATION

First and foremost, this dissertation is dedicated to my extraordinary mother, Judith, without whom I never would have begun this long, enriching journey of self-discovery and service to others in the first place, or had the will and means to complete it. Thank you for helping me discover my life's purpose, always encouraging me to do what I am most passionate about and helping me prove time and again that you can indeed "do anything you set your mind to." If I am a good psychologist, it is because I had such a wonderful teacher instill early on in me and personify what true empathy, compassion and selflessness is and how it is manifested in one's interactions with the world around him/her. I can only hope that my practice as a clinical psychologist is half as good as your natural gift for it.

I would also like to dedicate this to my fiancée, Pernilla, for her constant love, support and patience in never tiring of the person I would occasionally become throughout this process—moody and obsessive in my routines—and for putting up with all the displaced frustration and anger at times as well! Furthermore, I would like to thank her for always demanding the best in me and never settling for less than what I am capable of. As I have long said, you have the most beautiful spirit of anyone I have ever known, and your ceaseless desire to help those who are least fortunate in this world is an inspiration to us all.

Finally, I would like to dedicate this to my father, Albert, for helping cultivate the philosopher in me—the side of me I love and value most—and from which the topic of this dissertation emerged. Thank you for always challenging me to think "outside the



box,” teaching me to play the role of *devil’s advocate* very well, and for helping me see that Truth is hardly ever black and white, but often, very complex, messy and relative.

## ACKNOWLEDGEMENTS

I would like to acknowledge the following people who helped make this work a reality by inspiring, nurturing and supporting my true humanistic-existential self; as well as those who contributed incalculable hours of work in the form of insight, feedback and invaluable assistance in the completion of this project. I would like to extend a very special thank you to Dr. Susan Hall for her tireless work in helping to make sure I not only finished this endeavor, but did so to the best of my ability. Playing countless roles as supervisor, editor, colleague, consultant, friend and cheerleader, while always demanding excellence, your job was not an easy nor enviable one, but it was greatly needed and appreciated. Your passion and dedication to your students and your work within the field of psychology is truly exemplary.

I would like to extend a sincere thank you to my fellow lab members, Stacie Cooper Eshelman and Josina Grassi Moak. Without the two of you this project would not have been possible, nor hardly as bearable. I could not have asked for two more amazing people with whom to complete this journey. Thank you Stacie for your contagious optimism and sunny disposition, as well as for being my “human calendar” much of these past six years—making sure I was always “on top” of everything I needed to be for school, dissertation and, at times, life. Thank you Josina for providing a degree of levelheadedness, lightheartedness and much needed perspective during the many long hours of our group meetings—it was a welcomed relief and kept me from going “crazy” many a time.

I would also like to express my sincere gratitude to Dr. David Elkins for being my spiritual mentor these past three years, for inspiring me to always believe in myself and

*trust my gut*, and for igniting the humanistic-existential fires within me. Your incredibly caring, magnanimous spirit, combined with revolutionary zeal for what you believe is true and right is something I aspire to in my own life.

Finally, I would like to thank Dr. Tom Greening for the inestimable knowledge, wisdom and insight he contributed to this work, as well as for his passion, respect for, and way with words—something I hope to continue cultivating in my own life.

## VITA

Alexander M. Bacher

## EDUCATIONAL HISTORY

Doctorate in Clinical Psychology (Psy.D.), Class of 2009  
 Pepperdine University, West Los Angeles, CA  
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 Cumulative GPA 3.85

Master of Arts in Clinical Psychology with an emphasis in Marriage and Family Therapy,  
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Bachelor of Arts in Psychology, Class of 2001  
 Georgetown University, Washington D.C.  
 Cumulative GPA 3.5; Deans List

Georgetown University's Villa Le Balze, Florence, Italy  
 Spent Semester Studying Abroad August 2000-December 2000

High School Diploma  
 The Browning School, New York, NY  
 Valedictorian for Class of 1997; High Honors all Four Years;  
 Captain of varsity baseball and soccer teams

## CLINICAL EXPERIENCE

Pre-Doctoral Intern  
 Metropolitan State Hospital  
 Norwalk, CA

September 2008-Present (40 hours per week)

- Presently completing all requirements for pre-doctoral internship at an APA accredited inpatient hospital for both forensic and civilly committed individuals
- Dialectical-Behavioral Therapy (DBT) Rotation (4 months)
  - Provide individual, group and milieu DBT therapy for inpatient population diagnosed with Borderline Personality Disorder and other severe Axis I diagnoses
  - Teach DBT skills to individuals for crisis management and emotion regulation
  - Consult with interdisciplinary team on a daily basis regarding treatment planning, adherence and outcome for individuals
  - Participate in weekly Wellness and Recovery Team meetings
  - Co-lead bi-weekly DBT skills group

- Co-lead weekly Acceptance and Commitment Therapy (ACT) group
- Attend weekly DBT consultation and trigger meetings
- Assist in the development and implementation of behavioral plans for individuals when indicated
- Maintain clinical documentation to ensure adherence to ethical and legal requirements
- Neuropsychology Rotation (4 months)
  - Provide Neuropsychological assessments of individuals with histories of traumatic brain injury, chronic substance abuse and severe mental illness
  - Consult with the Wellness and Recovery Teams in regard to an individual's cognitive functioning
  - Provide cognitive rehabilitation for individuals with cognitive dysfunction
  - Co-lead 8 hours of group therapy each week for the following groups (court competency; Acceptance and Commitment Therapy; Substance Recovery)
  - Maintain clinical documentation to ensure adherence to ethical and legal requirements
- Substance Abuse Recovery Rotation (SAR) (4 months)
  - Assisting in the development of a comprehensive, 15-week substance abuse treatment program which will eventually be implemented hospital wide as part of the hospital's Psycho-Social Rehabilitation model of treatment
  - Assisting in the training of providers to effectively administer and score substance abuse related assessment measures including the SOCRATES and ASI
  - Provide 8 hours of group therapy each week, two of which are specifically for Substance Recovery
  - Research and write chemical dependency related articles for quarterly SAR newsletter disseminated state wide to all hospitals

#### Peer Supervisor

Pepperdine University

September 2007-August 2008 (8 hours per week)

- Conducted weekly supervision of 1<sup>st</sup> year doctoral students performing individual therapy at the Union Rescue Mission
- Duties included supervision of student's skills in the following areas: intake assessment; diagnosing; boundary setting; development of therapeutic relationship; transference/counter-transference; goal setting; legal/ethical; and multicultural issues

#### Psychologist Trainee

VA Sepulveda Ambulatory Care Center

North Hills, CA

August 2007-August 2008 (20 hours per week)

- Outpatient Mental Health Rotation (6 months)

- Performed intake assessment, diagnosis, and treatment planning for veterans coming in for outpatient mental health services
- Conducted weekly individual psychotherapy sessions with 4-5 veterans presenting with bi-polar, depression, PTSD and other anxiety disorders
- Consulted with interdisciplinary team on a weekly basis
- Participated in bi-weekly staff meetings
- Maintained clinical documentation to ensure adherence to ethical and legal requirements
- Partial Hospitalization Program (6 months)
  - Performed intake assessment, diagnosis, and treatment planning for veterans coming in for day treatment services
  - Conducted weekly individual psychotherapy sessions with 4-5 veterans who were chronically/severely mentally ill or suffering from major dual diagnosis disorders such as bi-polar or PTSD co-morbid with chemical dependency
  - Co-led two weekly experiential process groups
  - Consulted with interdisciplinary team on a weekly basis
- Conducted weekly couples therapy sessions with two couples experiencing marital distress
- Administered and interpreted neuropsychological test batteries
- Conducted psychodiagnostic interviews and any necessary test batteries
- Attended weekly neuropsychological assessment training with Dr. Steve Ganzell
- Attended weekly didactic training on marriage-family therapy with Dr. Herbert Goldenberg

#### Psychologist Trainee

The Tarzana Treatment Center

Tarzana, CA

August 2006- August 2007 (22 hours per week)

- Performed intake evaluations, assessments and diagnosing of adult clients coming in for detox and inpatient services
- Provided individual and family outpatient therapy to dual-diagnosis adolescent clients in recovery from drug and alcohol dependence
- Completed individual clinical assessments to create individualized treatment plans
- Conducted psycho-educational group sessions to increase clients' knowledge on the process of addiction and recovery
- Co-led weekly multi-family group involving adolescents and their parents exploring issues related to addiction, trust, communication, and independence
- Developed and led a weekly Mindfulness based spirituality group for adolescents
- Conducted weekly case presentations to update treatment team of clients' progress in treatment
- Completed clinical documentation to ensure adherence to ethical and legal guidelines
- Attended weekly didactic training seminar on Addiction Treatment, Crisis Intervention, and Psychological Emergency Assessments with Dr. Melodie Schaeffer.

Psychologist Trainee  
The Union Rescue Mission  
Los Angeles, CA

September 2005- June 2006 (15 hours per week)

- Performed intake evaluation, assessment and diagnosing of homeless clients living at the Mission and on Skid Row
- Provided individual counseling to clients with severe, chronic mental illness, usually co-morbid with chemical dependency
- Performed case management and crisis management duties on an as-needed basis
- Maintained a case load of 6 individual clients seen on a weekly basis
- Completed necessary documentation to ensure adherence to ethical and legal guidelines
- Attended trainings on multi-cultural sensitivity
- Attended weekly group supervision and training on MCMI-III with Dr. Stephen Strack

MFT Trainee  
South Bay Center for Counseling  
El Segundo, CA

January 2004-July 2005 (20 hours per week)

- Conducted over 250 hours of individual therapy with adults and children
- Worked closely with the Clinic Supervisor and the head of Human Resources in designing and implementing a new substance abuse intervention group for at risk teens
- Led the weekly group therapy sessions for the new teen program
- Maintained a case load of 5-8 individual clients seen weekly in addition to performing phone intakes and other clinic duties

#### OTHER PSYCHOLOGY RELATED ACTIVITIES

Posters / Presentations:

- Co-presenting two symposiums this summer at the annual APA conference in Toronto, Canada (one for the general conference and another for Division 29 Psychotherapy) based off talk entitled “Shaking the Foundations” mentioned below
- Co-presented talk entitled “Shaking the Foundations” at the 2<sup>nd</sup> Annual Existential-Humanistic Conference (Nov. 2008 in San Francisco)
- Presented Poster entitled “Meaning Making and Hope in Therapy Sessions” at the 2<sup>nd</sup> Annual Existential-Humanistic Conference (Nov. 2008 in San Francisco)

Conferences / Continuing Education:

- Nov. 2008 – 2<sup>nd</sup> Annual Existential-Humanistic Institute Conference (2 full days)
- Feb. 2008 – New Center for Psychoanalysis – Otto Kernberg on Couples and Relatedness (1 full day; 6 CE Credits)
- Aug. 2007 – APA Annual Conference in San Francisco (3 full days)

- Dec. 2006 – The 6<sup>th</sup> Brief Therapy Conference (4 full days; 28 CE Credits)
- Feb. 2006 – The James S. Grotstein Annual Conference – Consciousness: Its Mystique and Emerging Clinical Importance (6 CE Credits)
- Dec. 2005 - Evolution of Psychotherapy Conference (6 full days; 42 CE Credits)

## OTHER WORK EXPERIENCE

### Research Analyst and HR Assistant

The Blackstone Group

New York, NY

March 2002—July 2003 (40 hours per week)

- Provided research materials necessary for all deals the company worked on
- Assisted the HR Group with the rolling out of a new end-of-the-year review system
- Assisted in the processing and evaluation of the firm-wide reviews

### Analyst-Investment Banking Technology Group

Merrill Lynch

New York, NY

July 2001-November 2001 & Summer 2000 (80 hours per week)

- Developed and performed valuation analyses for Technology Companies
- Helped complete a \$460,000,000 secondary stock/bond offering for a client
- Identified companies for possible Merger and Acquisition deals

### A.V.P. - Corporate Finance & Strategic Development & Founding Stockholder

Espernet.com

New York, NY

August 1999-December 1999 (80 hours per week)

- Took a one-semester leave of absence from college to work on \$150 million IPO for newly-formed consolidator of Internet Service Providers (ISPs)
- Involved in financial assessment of and due diligence on 43 ISP acquisitions completed in three months
- Assisted the CFO in compiling the financial data on all 43 acquired ISPs for the S1 Registration filing; co-authored and edited S1 Registration Statement
- Worked with the Controller and CFO on preparing quarterly financial statements
- Assisted the CEO in creating strategic business partnerships/alliances with other technology companies

### Summer Intern/Research Associate

The Blackstone Group (A world renowned investment advisory and private equity firm)

New York, NY

Summer 1999 (40 hours per week)

- Assisted Research Analysts at this private investment/merchant bank in researching and analyzing various industries and companies



- Extensive use of research databases such as Bloomberg, Factset, Disclosure, and Dow Jones Interactive; oversaw control and maintenance of Research Library

#### HOBBIES / INTERESTS

- Traveling/exploring new places and cultures– traveled to over 65 countries on 5 continents
- Cooking; attending theater; skiing; rollerblading; mountain biking; swimming; reading

## ABSTRACT

Finding meaning has long been considered a critical component in human development and flourishing (Carlsen, 1991; Erikson, 1968; Frankl, 1959), but there has been relatively little qualitative research on how the meaning-making process occurs within psychotherapy. The purpose of this study was to explore therapy clients' processes of making-meaning as well as the factors which hinder its resolution. Archival videotapes of 5 adult clients of diverse age, gender, ethnicity, religious/spiritual orientation and presenting issues were observed during their 3<sup>rd</sup> or 5<sup>th</sup> psychotherapy session at a university's community counseling clinic.

Employing a content analytic approach, the researchers used a modified version of the Change and Growth Experiences Scale (CHANGE; Hayes & Feldman, 2005) to code and examine client statements related to the meaning-making process. CHANGE codes included cognitive-emotional processing, unproductive processing, and historical antecedents. Results indicated that the process of making-meaning is complex and appears to occur on a continuum with insight and/or realization at one end of the spectrum and uncertainty and rumination at the other. One's position on this continuum appeared to be affected, in part, by clients' levels of rumination and uncertainty (the primary unproductive processing themes); for example, some clients' expressions contained both unproductive processing and cognitive-emotional processing. The primary cognitive-emotional processing themes discovered across participants included: questioning, explaining, justifying, realization, reflecting, and mindreading. Further, our findings indicate a large social/interpersonal component to the meaning-making process,

which is in accord with previous literature (Cacioppo, Hawkley, Rickett, & Masi, 2005; Debats, 1999; Mascaro & Rosen, 2005).

Finally, examination of therapist questions preceding client coded statements found that a more open and non-direct therapy approach (i.e., asking open-ended questions; making empathic reflections/statements) was more likely to be followed by cognitive-emotional processing, than a more direct therapist approach (i.e., asking direct or closed-ended questions; giving advice; making interpretations). In order to further clarify the meaning-making process of clients in psychotherapy, more attention should be paid to microanalyses of verbal and non-verbal interactions between therapists and clients, including a consideration of variables found to be associated with meaning-making in this study (i.e., hope, avoidance, rumination, uncertainty, and past social interactions).

## INTRODUCTION

Since Viktor Frankl first published *Man's Search for Meaning* (1959) along with his ideas about Logotherapy and how a lack of meaning and purpose can contribute to psychological difficulties, increased attention has been focused on the role meaning and purpose play in people's lives in general, as well as in the causes and remediation of psychological distress. More specifically, high levels of meaning in one's life has been directly associated with life satisfaction (Chamberlain & Zika, 1988), happiness (Debats, Van der Lubbe, & Wezeman, 1993), work enjoyment (Bonebright, Clay, & Ankenmann, 2000), psychological well-being (Zika & Chamberlain, 1987, 1992), and effective coping with stressful life events (Debats, Drost, & Hansen, 1995). Conversely, a lack of meaning has been associated with a greater need for therapy (Battista & Almond, 1973), psychological problems (Kinnier, Metha, Keim, & Okey, 1994; Kish & Moody, 1989; Yalom, 1980) depression and anxiety (Debats, Van der Lubbe, & Wezemen, 1993; Pennebaker, Colder, & Sharp, 1990), and suicidal ideation and substance abuse (Harlow, Newcomb, & Bentler, 1986).

Although a great deal of quantitative research has demonstrated a link between meaning and psychological functioning, there has been relatively little qualitative research focused on how meaning is created in the therapy process (Clarke, 1996; Skaggs & Barron, 2006; Strong, 2003). The purpose of this research, then, was to examine how clients create and use meaning in psychotherapy. The study took place within a positive psychology framework because of positive psychology's emphasis on examining positive character traits such as meaning-making. Accordingly, a brief discussion of positive psychology, including its definition, history and relationships to meaning-making is

provided, along with a critical analysis of this perspective. Then, multiple models of meaning-making and meaning as a construct are discussed, with an emphasis on situational and global meaning-making theory. Finally, a brief summary of how the construct of meaning has been measured is presented.

## Positive Psychology

### *Historical Background of Positive Psychology*

From its beginnings, psychology and its study of human behavior and functioning has adhered to the deficit-laden, medical model approach of examining what is wrong with people (Gable & Haidt, 2005). In doing so, the past century has produced a plethora of information regarding what is wrong with people and how psychological problems or “mental illness” arises, while we have learned very little about how people flourish and thrive. For example, since 1887, approximately 70,856 research articles on depression have been published, versus only 2,958 on happiness (Myers, 2000). This is not to say that all past work has been in vain but, rather, it is simply incomplete. Many successful treatments have been derived from the focus on how and why people become distressed or ill; however, present research is suggesting that even better treatments can be developed by understanding and focusing on what is “right” with people (Maddux, 2002).

This desire to focus on people’s strengths and how they flourish is not a new idea but, in fact, has been proposed a number of times in the past; it simply never took hold among the mainstream theories of the day because it was said to lack the empiricism that our Western society values so much (Duckworth, Steen, & Seligman, 2005). Some of the major predecessors who laid the foundation for the positive psychology movement include William James (1902) and his writings on healthy mindedness, Gordon Allport

and his focus on positive human characteristics (1958), Viktor Frankl and his development of Logotherapy (1967), and Abraham Maslow (1968) and his push for the study of healthy people, rather than sick people. Furthermore, Carl Rogers and the Humanistic psychology movement emphasized the client's capacity for growth and an increased interest in exploring concepts such as psychological functioning, values, feelings, and goals (Kirschenbaum, 2004). Humanistic psychology first made the attempt to counter all the attention being paid to the medical model of "mental illness. The more dominant forces of psychology at that time, however, tended to either ignore and/or misperceive the humanistic movement's research and other contributions to the field, leading to its work being marginalized (Elkins, n.d.). Presently, positive psychology can be seen as revitalizing this effort to shift attention away from the medical model and appears well positioned to continue doing so, due to its emphasis on scientific research, practice and intervention (Simonton & Baumeister, 2005).

The positive psychology movement began in the late 1990s, with Martin Seligman and Mihaly Csikszentmihalyi as its pioneers, in an attempt to correct the imbalance in understanding what factors help individuals and communities to thrive. The adherents of this movement study the conditions and processes that contribute to the flourishing, or optimal functioning, of people, groups and institutions (Gable & Haidt, 2005). Positive psychology's main inauguration to the field of psychology and the rest of the world came in January 2000, with a special issue of the *American Psychologist* devoted to explaining the movement's philosophical ideas, present empirical findings and future goals for the betterment of humanity. In it, Seligman and Csikszentmihalyi (2000) laid the theoretical foundation for what became the movement's three pillars, or focus of

research: positive emotions, positive character traits and positive institutions. Positive psychologists believe that by focusing on and exploring strengths rather than exclusively focusing on weaknesses, people will develop better self-esteem, optimism, and a sense of purpose that will not only aid in overcoming the damage of disease, stress and disorder but, in addition, will help them achieve more authentic, meaningful lives (Keyes & Lopez, 2002).

Research in positive psychology has found evidence that optimism and a sense of personal control are protective factors for psychological and physical health (Taylor, Kemeny, Reed, Bower, & Gruenwald, 2000). Other human strengths, studied by prevention researchers, act as buffers against mental distress, including: courage, future mindedness, optimism, interpersonal skills, faith, work ethic, hope, honesty, perseverance, and insight (Seligman & Csikszentmihalyi, 2000). These and other human strengths have since been categorized in the *Values in Action (VIA) Classification of Strengths Manual* (Peterson & Seligman, 2004). This resource provides information regarding various strengths, similar to the way the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* provides information about pathology and mental disorder. In the VIA manual, 24 strengths similar to the ones mentioned above are broken down into six overarching virtues which are believed to be universal characteristics necessary for evolutionary survival. The data collected thus far from different countries reveals near universal acceptance of these virtues, which include the following: wisdom and knowledge, courage, humanity, justice, temperance, and transcendence (Dahlsgaard, Peterson, & Seligman, 2005; Peterson & Seligman, 2004); although additional multicultural research is recommended. Positive psychology's mission, then, is to better

understand how these strengths come to manifest themselves in people, in order to help foster them in others who lack them.

### *Definition of Positive Psychology*

Although still in its initial stages, the positive psychology movement has received much attention and gained a strong following. With all this fanfare and people interpreting its mission in different ways, the movement's original purpose and goals have, at times, been greatly misconstrued and misunderstood (Lazarus, 2003). Therefore, in order to remain as true to the movement's ideals as possible, we refer to the positive psychology manifesto for the definition of positive psychology:

Positive Psychology is the scientific study of optimal human functioning. It aims to discover and promote the factors that allow individuals and communities to thrive. The positive psychology movement represents a new commitment on the part of research psychologists to focus attention upon the sources of psychological health, thereby going beyond prior emphases upon disease and disorder. (Sheldon, Frederickson, Rathunde, Csikszentmihalyi, & Haidt, 2002, ¶ 2)

### *Critique of Positive Psychology*

Yet, as with anything that is introduced as new and different, there have been a number of critics and challengers of the positive psychology movement. One of the most common criticisms involves the assumption that if there is a "positive" psychology, then the rest of the psychology field must be "negative" and ineffective (e.g., Gable & Haidt, 2005). Similarly, another criticism is that positive psychology and its adherents have a Pollyannish view of the world that fails to take into account the negative aspects of life, which are natural and experienced by everyone at times (Lazarus, 2003). Existential psychologists contend that positive psychology emphasizes too strongly the positive, "let's all be happy" idea of a "good life" rather than one embracing all of its complex forms, including the good, the tragic and the painful (D. N. Elkins, personal



communication, April 7, 2009; Robbins, 2008). Robbins explains that the positive psychology worldview reflects its American heritage of extreme and, at times, almost tyrannical happiness. This perspective of extreme happiness has been perceived by many to be based off a hedonic view of the good life (i.e., simply looking at the ratio of pleasure to pain in one's life as a determinant of one's overall well-being in life), which fails to appreciate the natural, unpleasant states of mind and the learning and growth which usually accompany them (Lazarus).

In response, positive psychologists point out that these inferred assumptions of positive psychology are unfortunate and simply not true (Rand & Snyder, 2003). Positive psychology recognizes that often much good can come out of pain and suffering and that, for some, it might be necessary to experience the proverbial sour in life before one can fully appreciate the sweet or good life. In addition, positive psychology desires not to eliminate all research conducted on pathology but to expand our knowledge of human strengths and virtues to develop a more balanced understanding of human functioning (Rand & Snyder).

Another major criticism of positive psychology has to do with the view that it offers nothing new; that it has not acknowledged or has re-packaged information and theories from the past (Elkins, in press; Lazarus, 2003). To this, both Seligman and Csikszentmihalyi say they readily agree. From the start, both have been quite clear in stating they do not pretend to have discovered something new, but, rather, wish to add a new scientific foundation to older, ethereal theories (Csikszentmihalyi, 2003; Seligman & Csikszentmihalyi, 2000).

However, many have accused Seligman and his colleagues' actions as speaking louder than, and opposite from, their words (Bohart & Greening, 2001; Held, 2004). Elkins (in press) states that Seligman and the positive psychology movement have not discovered something new but have simply re-ignited the humanistic movement of the 1950s and 1960s in a new way, which is more acceptable to mainstream psychology and the political forces which determine its direction. Positive psychology should redress its perceived past insults to its humanistic forefathers and give credit where it is due. For example, it needs to recognize the invaluable contributions of Carl Rogers, including his research; a collection so great that he is often referred to as "the father of psychotherapy research" (Elkins, n.d., p. 4). This research achievement is a far cry from the purported lack of empiricism Seligman provides as one of the reasons the humanistic movement failed to flourish.

After celebrating humanistic psychology and more explicitly recognizing its contributions to positive psychology, positive psychologists should join forces with humanistic psychologists to battle against the medical model. Although rightly offended by the lack of due credit, humanistic psychologists also need to recognize and seize the invaluable opportunity at present. They should use the momentum positive psychology has garnered, in conjunction with the emerging contextual factors research that shows the inadequacies of the medical model, to re-affirm to the field Roger's goals of empowering the client and creating the necessary and sufficient conditions for the client to change on his/her own.

Other criticisms of the positive psychology movement involve the means by which it attempts to accomplish its difficult task of defining ambiguous terms,

operationalizing vague constructs in an attempt to measure them, measuring complex variables such as emotions, and determining what is considered positive or good/healthy in multicultural contexts (Held, 2004; Lazarus, 2003). Robbins (2008) contends that positive psychology is in apparent denial regarding its ability to conduct value neutral research into how happiness or well-being is created and manifested by people. By continuing to ignore the implicit American values underlying its research, positive psychology risks imposing Western, individualistic values upon others.

Positive psychologists recognize, however, that determining what is positive or good is usually based on some value system or set of cultural norms to which a person has been exposed, and that collective beliefs regarding what is acceptable and unacceptable can influence decisions about what goals to pursue (Diener & Suh, 1997). In addition, they understand that something considered positive and acceptable in one culture might be seen as negative and unacceptable in another; a 'one size fits all' approach to treatment and understanding in our multicultural world does not work (Flores & Obasi, 2003; Lopez et al., 2002; Norem & Chang, 2002).

The fact that what is considered positive or good is complex and multi-dimensional must be considered when developing empirical designs and theories. Positive psychology attempts to handle this intricacy by focusing more on the complex interactions of various constructs in specific contexts over time, rather than simply describing their main effects (Csikszentmihalyi, 2003). Furthermore, Csikszentmihalyi calls the criticism over positive psychology's intermittent use of cross-sectional research designs ironic, considering the same can be said of most psychology research in general. Finally, positive psychology takes the influence of culture very seriously and, in its brief

existence, has already made significant inroads on the way to understanding how strengths and virtue differ in various cultures around the world (Park, Peterson, & Seligman, 2006). As previously mentioned, six virtues have been discovered thus far in cross-cultural research: wisdom, courage, humanity, justice, temperance, and transcendence (Dahlsgaard et al., 2005); although continued awareness into how positive psychology's implicit values affect their cross-cultural research is needed (Robbins, 2008). Of these virtues, transcendence, or one's search for connection with the surrounding universe in order to provide meaning and purpose in one's life, is the focus of this study.

## Meaning

### *The Construct of Meaning*

Meaning imbues everything in our realities with value, belief and understanding, as its purpose comes from our human need to make sense of ourselves and the world around us. Frankl (1963) suggested that all humans have a "will to meaning," or an innate drive to find meaning and significance in their lives; failure to do so results in psychological distress. When a lack of meaning exists, it leaves one lost or in a state of identity crisis (Erikson, 1968; see also Carlsen, 1991). Meaning, then, helps provide humans with a type of roadmap to their lives that helps them navigate the world in a way that is congruent with their being and the being of others.

Although a will to meaning may be shared by all people, its experience is subjective and, consequently, its definitions vary. Some of the ways meaning has been defined in the past include: coherence in one's life (Reker & Wong, 1988), goal directedness or purposefulness (Ryff & Singer, 1998), "the ontological significance of

life from the point of view of the experiencing individual” (Crumbaugh & Maholick, 1964, p. 201), “the ‘felt sense’ of an experience” (Clarke, 1996, p. 465), and “the sense made of, and significance felt regarding the nature of one’s being and existence” (Steger, Frazier, Kaler, & Oishi, 2006, p. 81). One way to reconcile the various definitions is to examine Park and Folkman’s (1997) concepts of situational and global meaning.

Situational meaning involves an appraisal of a situation a person has experienced, while global meaning refers to a person’s enduring beliefs, values, goals, assumptions and expectations about the world (Park & Folkman).

Similarly, the suggested ways of obtaining meaning in one’s life are just as numerous: pursuing important goals (Klinger, 1977), developing a coherent life narrative (Kenyon, 2000; McAdams, 1993), achieving self-transcendence (Allport, 1961; Seligman, 2002) and following organized religion (Baumeister & Vohs, 2005). Studies examining how adults make meaning out of trauma or loss have found the following factors to be an important component of the meaning-making process: creating illusion (Taylor, 1983), positive reappraisal (Folkman & Greer, 2000), reattribution (Park & Folkman, 1997), developing a verbal account or narrative (Harvey, Orbuch, & Weber, 1990), helping others (Kishon-Berash, Midlarasky, & Johnson, 1999), revaluing ordinary events and engaging in problem-focused coping (Folkman & Moskowitz, 2000). Meaning can also be seen as obtained when a person reconciles situational and global meaning by meeting one’s needs for value, purpose, efficacy and self-worth (Baumeister, 1991; Baumeister & Wilson, 1996; Park & Folkman, 1997). Because this latter conceptualization is felt to encompass the strengths of other ways of defining meaning, it will be discussed next in greater detail.

### *Reconciling Situational and Global Meaning*

The process of realigning one's global and situational meaning usually takes place in a narrative form—with the person constructing a story of past events in an attempt to make sense of them (Clarke, 1996; McAdams, 1993). In this way, people impose meaning on their lives. This is often done when people lose sight of meaning as a result of some experience or event.

Park and Folkman (1997) describe the breakdown of meaning as peoples' inability to reconcile their situational meaning, or their appraisal of some situation they have experienced, with their global meaning, defined as a person's enduring beliefs, values, goals, assumptions and expectations about the world. Discrepancies between these meaning systems usually lead to uncertainty and negative rumination, which can increase feelings of anxiety/despair (Bar-Anan, Wilson, & Gilbert, 2009; Morrow & Nolen-Hoeksema, 1990; Pennebaker et al., 1990; Ray, Wilhelm, & Gross, 2008).

To help alleviate these negative feelings and regain healthy goal-directed behavior, Park and Folkman suggest that one must go through a process of cognitive reappraisal where one can integrate his/her situational and global meaning in a congruent way that achieves resolution. Just as Clarke (1996) believes people use meaning-making as a linguistic translation of one's experience-based feelings in order to better understand and make sense of what is happening to them, this process occurs at the level of global and situational meaning in people's lives. The creation, and occasional re-examination, of global meaning would be in response to the feeling of existential anxiety and despair every human being faces upon learning of and reflecting on his/her mortality (Yalom,

1980). Situational meaning would be created and re-examined in response to other anxiety-provoking situations experienced more frequently and to a lesser degree.

During times when one's situational anxiety and despair become unmanageable, causing incongruence between situational and global meaning, a person needs to explain the reason for this occurrence by applying meaning to it in a way that will realign it with their global meaning concept. This process of realigning one's situational and global meaning is sometimes called coping (Baumeister, 1991; Thompson 1985). It usually involves, to some degree, an examination of people's purpose, values and justifications, self-efficacy and self-worth, or the four needs of meaning (Baumeister & Wilson, 1996).

According to Baumeister and Wilson (1996), purpose is important because it imbues events and actions with meaning by recognizing them as steps towards certain desirable ends. Value and justification are necessary in order to have some way of defining one's actions as moral and good. Efficacy is important because it helps people feel responsible for the positive outcomes they experience as a result of their purposeful efforts and actions. And self-worth, then, comes as a by-product of a person's feeling able to or responsible for performing purposeful, value-laden actions, which lead to positive outcomes for his/her self and others. One's recognition of this process, and his/her role in it, helps create meaning in life and feelings of self-worth, both of which help maintain healthy psychological functioning (Baumeister & Wilson). When this process leads to a healthy realignment of one's global and situational meaning, distress is avoided and healthy functioning can be maintained. In addition to one's internal process, social connectedness plays a major role in one's meaning-making system (Cacioppo, Hawkey, Rickett, & Masi, 2005; Debats, 1999; Mascaro & Rosen, 2005). Cacioppo et al.

suggest that the way people think about and perceive the world around them is greatly influenced by feelings of social connectedness.

### *Outcomes of Meaning*

Theorists widely agree that meaning is crucial to human beings (Steger et al., 2006). For example, existential psychology suggests that people's ability to create and develop meaning and purpose in many areas of their lives is vital to healthy psychological functioning. Having high levels of meaning in one's life has been directly associated with authentic living (Kenyon, 2000), life satisfaction (Chamberlain & Zika, 1988), happiness (Debats et al., 1993), work enjoyment (Bonebright, Clay, & Ankenmann, 2000), psychological well-being (Zika & Chamberlain, 1987, 1992), and effective coping with stressful life events (Debats et al., 1995). In regards to psychological well-being, pursuing meaningful goals and having purpose in one's life have been found to play major roles in its acquisition, along with self-acceptance, personal growth, positive relations with others, environmental mastery and autonomy (Keyes & Lopez, 2002; Ryff & Keyes, 1995). Research has not established a link between wellness enhancement and meaning-making, as it has focused more on prevention of health issues (Cowen, 2000).

Additionally, it has been suggested that much "mental illness," at its root, has to do with a lack of transcendent meaning and purpose in one's life (Frankl, 1963). Research has supported proposed links between people's lack of meaning and psychological distress. A lack of meaning has been associated with greater need for therapy (Battista & Almond, 1973), and mental health problems (Kinnier et al., 1994; Kish & Moody, 1989; Yalom, 1980) such as depression and anxiety (Debats et al., 1993;



Pennebaker et al., 1990) and suicidal ideation and substance abuse (Harlow, Newcomb, & Bentler, 1986).

### *Meaning-Making in Psychotherapy*

Because meaning-making appears to be associated with positive and negative outcomes that may indicate a need for psychotherapy, understanding the role and process of meaning-making in psychotherapy is essential. When one considers mainstream theoretical orientations, one finds that at their theoretical core, they rely on helping clients come to some form of understanding or awareness of their unconscious/automatic thoughts, processes, and/or behaviors. This understanding, accompanied by acceptance (and some personal change or transformation, or at least a desire to do so), arguably serves to provide some meaning and order in peoples' lives and in the world around them. It is this illusion of predictability in one's world, which provides a sense of relief and comfort to whatever is presently upsetting him or her (Skaggs & Barron, 2006). Thus, although many traditional psychotherapies may not explicitly focus on the term "meaning," they employ aspects of meaning-making in their processes (Dyck, 1987; Kuehlwein, 1996).

But the recent explosion of post-modern orientations to psychotherapy has as its main goal clients' re-construction of a meaning system acceptable to their lived experiences to date, providing clients with both a "why" and "how" to best live and cherish their lives going forward. So, instead of searching for the historical antecedents of a client's present problem, post-modern approaches, such as narrative therapy and constructivism, emphasize the current meanings clients attach to past events (Rosen, 1996; White & Epston, 1990). As Waters (1994) states:

Instead of pursuing some central 'reality' dialogic, [constructivist] therapists reconstruct events to emphasize the best and most productive aspects of a person's current functioning, and to create the likelihood of more positive future functioning. (p. 73)

In short, narrative therapists help clients deconstruct the meaning of the reality of their lives and relationships, and enable them to see the difference between their reality and the internalized stories of self. The therapist then helps the clients to "re-author" their own lives according to alternative and preferred stories of self-identity and preferred ways of life (White & Epston, 1990).

The process of narrative therapy is very similar to the concept of constructivism, which holds that humans generate knowledge and meaning from their experiences (White & Epston, 1990). Constructivists suggest that individuals construct meaning through their interactions with one another and the environment in which they live (Cottone, 2001). Knowledge, then, is socially and culturally constructed as individuals engage in social activities (Cottone, 2001). The role of the therapist within constructivist thought is understood to be more of a facilitator, than a teacher (Cottone, 2007). Whereas a teacher may tell and lecture, a facilitator asks questions and guides the client, supporting him/her from the back, instead of lecturing from the front (Cottone, 2007). The goal of constructivist therapy is to assist the client in becoming an effective thinker by creating a supportive environment where one can arrive at his/her own conclusions about life and reality (Cottone, 2007). As a therapist, constructivist or otherwise, one must walk a careful line between not imposing one's own belief/value system upon the client, while at the same time helping the client derive a meaning system which is life enhancing and not life destroying, either for the clients, or others. Additionally, in order to best help the client function and thrive in his/her environment, the therapist should help the client

develop a meaning system that is grounded in social reality as much as possible, so as not to alienate him/herself from the social support of others.

We see, then, that meaning-making in general, and especially in psychotherapy, is an essential component, which simply cannot be ignored. Kuehlwein (1996) seems to agree when he says, “I believe that managed care organizations will eventually adopt meaning-making as an over-arching metatheory for all types of psychotherapy” (p. 511). Unfortunately, for the most part it has gone unexplored in terms of research conducted in the actual context of psychotherapy. As previously cited, many studies have explored meaning-making in individuals who have conditions that might bring them to therapy, and literature exists about what clinicians should do in psychotherapy to facilitate client meaning-making. However, no literature was located on how meaning was assessed, explored or expressed in psychotherapy sessions using a qualitative design.

### *Assessing Meaning*

Meaning as a construct has been measured in multiple ways in the past. Some of the main assessment tools included: the Purpose in Life Test (PIL; Crumbaugh & Maholick, 1964), the Life Regard Index (LRI; Battista & Almond, 1973), the Sense of Coherence Scale (Antonovsky, 1987), and the Purpose in Life subscale of Ryff’s (1989) measure of psychological well-being. Since the construct of meaning is complex, subjective and difficult to assess, many researchers have taken a more qualitative approach in their efforts to assess its presence and understand its process of creation. In terms of trying to understand the process of meaning-making, researchers have employed the following qualitative designs with adults who lost a loved one or who, themselves, were diagnosed with cancer, HIV or some other major medical illness: grounded theory

(Courtenay, Merriam, & Reeves, 1998; Halstead, & Hull, 2001; Landmark, Strandmark, & Wahl, 2001), content analysis (Grossman, Sorsoli, & Kia-Keating, 2006), thematic analysis (Lewis, 1995; O'Connor, Wicker, & Germino, 1990) and hermeneutic phenomenology (Nelson, 1996; Ohman, Soderberg, & Lundman, 2003).

Some qualitative measures which have been used in the past with adults to measure meaning or aspects of meaning-making include: O' Cleirigh et al.'s (2003) measure of depth processing, the Assimilation of Problematic Experiences Scale (Stiles et al., 1990), the Experiencing Scale (Klein, Mathieu-Coughlan, & Kiesler, 1986), the Narrative Processes Coding System (Angus, Levitt, & Hardtke, 1999) and the CHANGE scale (Hayes, Feldman, & Goldfried, 2007). All the aforementioned measures, except the CHANGE scale, tended to place insight-processing, rumination and avoidance of processing on the same continuum as one single variable, or exclude categories that assessed avoidance processing or ruminative insight-seeking in their attempts to measure the degree of meaning-making. Only the CHANGE scale broke these three related meaning-making components out into separate variables, whose outcomes and correlates could be studied individually. Thus, these qualitative measures helped bring a more detailed assessment of the constructs they were measuring; however, they fail to explain the processes which underlie their findings. Continued examination of meaning-making in the context of psychotherapy fits with the goal of strength-based assessment in positive psychology (Snyder et al., 2003; Walrath, Mandell, Holden, & Santiago, 2004).

#### Purpose of the Present Study and Research Questions

Because prior research has implicated meaning, and its lack thereof, as a significant contributor of both physical and psychological problems (Battista & Almond,

1973; Debats et al., 1993; Harlow et al., 1986; Kinnier et al., 1994; Kish & Moody, 1989; Pennebaker et al., 1990; Yalom, 1980) as well as physical and mental health (Chamberlain & Zika, 1988; Debats et al., 1995; Debats et al., 1993; Zika & Chamberlain, 1987, 1992), it appears important to assess how this construct is created and used in the context of psychotherapy. It is not known whether previous research findings about how people make meaning after being diagnosed with serious illness, dealing with the loss of loved ones and experiencing negative life events extend to how meaning-making actually occurs in the therapeutic context. The purpose of this study, therefore, was to better understand adult psychotherapy clients' subjective expressions of meaning-making through content analysis. Accordingly, the two research questions in this study were: How do adult clients express meaning during intake sessions at a university community counseling center? What are the major processes by which clients make meaning during intake sessions at a university community counseling center?

## METHOD

The purpose of this chapter is to provide an explanation of the methods used in this study. The section describes the research participants, the instruments used, the design of the study, and the data collection and analysis procedures.

### Participants

The sample included 5 participants whose audio or videotaped psychotherapy sessions were accessed via an archival research database from a university's community counseling centers and clinics in southern California. The research database was developed with Institutional Review Board (IRB) consultation and IRB approval was obtained prior to accessing archival client data. Five adult participants were chosen using purposeful random sampling based on general guidelines for qualitative and observational research (Creswell, 1998; Mertens, 2005). Participants were adults who sought counseling between 2004 and 2007 at one of the three university counseling centers. At the time of intake for therapy, clients voluntarily consented to have their written records and/or audio/videotaped sessions included in the research database (Appendix A). Therapists also gave written consent to have their taped sessions and written materials included in the database (Appendix B). In order to protect client and therapist confidentiality, all names were removed from videotapes and replaced with research codes, and steps were taken to ensure research coders did not know either the client or therapist on any of the videotapes.

In order to be included in the study, clients had to be at least 18 years of age, fluent in English, and have provided written consent for written and either audio or videotaped session information to be recorded and included in the research database.

Furthermore, each client's data obtained from the database had to be sufficient and meet specific requirements. Inclusion criteria for "sufficient data" cases consisted of audible audio and/or video sessions from the entire first, second or third session, with accompanying completed measures at intake. Adult individuals coming to the clinics seeking couples or family therapy were excluded due to the design and scope of the study.

The participants included 3 females and 2 males whose ages ranged from 21 to 36 ( $M = 27.8$ ). They self-identified themselves as Asian-American, Polish-American, African-American, or Mexican-American. Members of the sample also considered themselves to be Catholic, Pentacostal, Unitarian, or not religious or spiritual. The sample's demographic characteristics are listed in Table 1.

Table 1

*Participant Demographic Information*

Participant	Age	Gender	Ethnicity	Religion
P1	21	Female	Mexican-American	Pentacostal Christian
P2	28	Male	African-American	None indicated
P3	25	Female	Polish-American	Catholic
P4	36	Female	Mexican-American	Unitarian
P5	29	Male	Asian-American	Non-religious

## Instrumentation

### *Client Demographics*

In order to create a representative clinical sample of the diverse population normally served by the three university clinics and counseling centers, demographic information was obtained from the research database and analyzed. Information pertaining to gender, ethnicity, age, marital status, religious/spiritual beliefs, presenting problems and psychological history was gathered from an adult demographic form completed by clients at their first session.

### *Change and Growth Experiences Scale (CHANGE)*

*Meaning-making.* Given the difficulties in assessing the ambiguous construct of “meaning-making,” a literature review was conducted using several psychology databases, including PsycINFO, PsycARTICLES, PubMed, Scopus, and Academic Search Elite. Search parameters used to identify relevant information included the use of terms such as: “Positive Psychology;” “meaning making or meaning-making;” “meaning;” “purpose;” “spirituality and psychotherapy;” “insight-oriented processing;” “observational research;” “qualitative analysis;” “content analysis;” and “depth processing.” To determine how far back in time to search for literature related to the construct of meaning, the author decided to use 1959, the publication date of Viktor’s Frankl’s work, *Man’s Search for Meaning*, because Frankl’s work spurred much research in the field of psychology on the role of meaning and purpose in people’s lives. Since the author of this study only speaks English, the literature reviewed was limited to that published in English.



During the literature review, both quantitative and qualitative measures of meaning were examined. Some of the quantitative instruments considered for use in this study included the Purpose in Life Test (PIL; Crumbaugh & Maholick, 1964), the Life Regard Index (LRI; Battista & Almond, 1973), the Sense of Coherence Scale (Antonovsky, 1987), and the Purpose in Life subscale on Ryff's measure of psychological well-being (Ryff, 1989). With time, the researchers concluded that a strictly qualitative approach to understanding this construct would add a much needed depth of understanding in how meaning is expressed and created in the context of psychotherapy.

After examining the relevant literature on qualitative measures of positive psychology variables (including qualitative scales, such as O' Cleirigh et al.'s (2003) measure of depth processing, the Assimilation of Problematic Experiences Scale (Stiles et al., 1990), the Experiencing Scale (Klein et al., 1986), and the Narrative Processes Coding System (Angus et al., 1999), only one instrument was found that was purposely created in the spirit of positive psychology—the Change and Growth Experiences Scale (CHANGE; Hayes et al., 2007). The CHANGE rating system was selected for use in this study for a number of reasons: (a) it was designed specifically to measure positive psychology-related constructs, including insight-processing or meaning-making, in either narratives or therapy sessions; (b) the unit of analysis for the CHANGE system is a full therapy session; (c) the coding system is relatively easy to learn; and (d) it has good psychometric properties (inter-rater agreement on all coding categories of .73 to .84) (Hayes et al.).

The CHANGE coding system examines seven content areas: view of self; sense of hope; emotion; behavior; somatic functioning; perceived relationship quality; and historical antecedents of current problems; as well as three client processes: protection/avoidance; cognitive/emotional processing; and unproductive processing (Hayes & Feldman, 2005; Hayes et al., 2007). The content areas are coded for intensity (low, medium, high) and valence (positive and negative), while the processes are coded by levels (low, medium, and high). Each variable in the scale is coded on a scale from 0 to 3 (0 = not present at all; 1 = low; 2 = medium; 3 = high). In addition, the variables are not mutually exclusive and can co-occur.

The meaning-making variable assessed in this study was found to be included in the following domains of the CHANGE scale: cognitive-emotional processing, unproductive processing and historical antecedents. The *cognitive-emotional processing* category was designed to capture the degree to which a person attempts to understand, challenge and make meaning of some problem he/she is facing. It is used to measure concepts that have been referred to in the literature as emotional processing, meaning-making, benefit-finding and schema change (Hayes & Feldman, 2005). Although this category contains aspects of both cognitive and affective change, processes like rumination, worry and other perseverative thoughts which cause affective arousal are not included due to their inability to cause a shift in perspective or lead to insight (these are accounted for in the unproductive processing domain).

This conceptualization of cognitive-emotional processing is very similar to the process of reconciling global and situational meaning as mentioned previously (Park & Folkman, 1997), which is how the present researchers have defined meaning-making.

Cognitive-emotional processing usually takes place in narrative form, in which people use reappraisal, reattribution and other revaluing techniques in order to better understand, or make sense of, some experience/aspect of their lives which is presently causing them distress. This is done in order to help realign their situational meaning (problematic experience; feelings) with their global meaning (enduring beliefs; values; goals; expectations about the world) and relieve any anxiety or despair associated with the incongruence.

Thus, in the coding system used in the present study, a level 1, or “Low” level cognitive-emotional processing code indicated a person’s exploring and questioning a problem area with some uncertainty and no significant insight. An example of a level 1 cognitive-emotional processing from the CHANGE scale’s manual (Hayes & Feldman) is: “I wonder why I am so scared of succeeding...why do I avoid the spotlight?” (p. 16). A level 2, or “Medium” level code indicated similar exploring and questioning of a problem area with more certainty and some new connections and insights, but no substantial perspective shifts. An example of a level 2 or “Medium” level code is: “I realized that I am afraid to succeed...I have been holding myself back because I am afraid to move too fast and then to fail” (Hayes & Feldman, p. 16). A level 3 or “High” level code is representative of someone who is actively engaged in exploring or confronting a problem area with substantial insight and perspective shifts—an “Ah-ha” like experience with physiological affective reaction. This can include making new meaning of experience, integrating past experience with current functioning, benefit finding, reframing, reaching a higher level of abstraction, and resolution/acceptance. An example of a Level 3 CHANGE processing code is:

I feel more solid. Bad things still come my way, but somehow I don't let things devastate me as I did before. I am starting to see that the bad things are not personal; they are part of being alive. (p. 16)

The unproductive processing category of the CHANGE attempts to capture the extent to which a person approaches a problem, explores it and tries to make meaning of/understand it, but becomes stuck in thinking about it—repeatedly analyzing it without achieving significant insight (Hayes & Feldman, 2005). Once again taken from the CHANGE scale manual, an example of a Level 1 unproductive processing would be: “I began to wonder why I had stayed so long in this unhealthy relationship. I think about him a lot, and I get mad at myself. I feel like I'm not getting anywhere” (p. 17). Whereas an example of a Level 3 unproductive processing could be: “I can't stop thinking about everything that I did to hurt him and how I have failed in relationships. I've failed at everything. I am haunted by a list of failures” (p. 17).

The historical antecedents domain of the CHANGE scale was created to capture the extent to which people look to early experiences with parents or early caretakers when identifying, exploring or examining issues related to their present problems (Hayes & Feldman, 2005). In addition to being scored on a 0 (low) to 3 (high) scale, this domain, unlike the previous two, is also coded as either positive or negative. In the scoring of this domain, higher scores reflect more elaborate discussions of historical antecedents as well as increased discussion integrating past experiences with current problems. An example of a high, negative historical antecedent would be the following, taken from the CHANGE coding manual:

My mother taught us that it was best to 'never air dirty laundry.' It was forbidden to go outside the family when there was a problem. No wonder it is so hard for me to ask for help when I need it. (p. 13)

Finally, because situations were encountered in which historical antecedents were present in a client's story, but were not related specifically to early parents/caregivers, the coders created a very similar, yet separate coding category to account for it. This category was referred to as historical antecedents not limited to early caregivers, and included the exact same coding criteria as the other historical antecedents category. This supplemental category pertained to any important early experiences the client had, which did not involve parents or early caretakers, but was somehow influential in identifying, exploring or examining issues related to their present problems, but was separate from them. An example of a high negative historical antecedent not limited to caregivers would be: "I started feeling anxious when I moved to Los Angeles because there is so much pressure to conform and fit in, which made me focus on my flaws and feel anxious." An example of a medium positive historical antecedent not limited to caregivers would be: "I always had a lot of support growing up in New York with my friends and these friends helped me get through ups and downs."

Lastly, because meaning-making often occurs within the context of a narrative process, each therapist's statement that immediately preceded a client's coded meaning-making statement was examined. This was done in order to determine how the therapist might have potentially influenced his/her client's meaning-making process. Codes consisted of: tracking statements (e.g., "ok;" "yeah;" "uh-huh"); reflection statements (e.g., "Yeah, so everything that you've worked for, your goal, which you just said, was financial stability, is now like pulled out from under you"); advice giving (e.g., "One of the best ways to clear your mind is to go running or workout or play your favorite sport"); interpretations (e.g., "Do you think that pressure might be self imposed?" "So in

the past it seems like you did use your church to kind of cope with stuff, right?"); supportive comments (e.g., "ok, good;" "They're your parents, I'm glad you're able to do that"); psychoeducation (e.g., "They are very sick people—they have a disease that they don't know what they're doing or how they're doing and how it affects everyone else"); direct questions (e.g., "Have you ever felt like you were drinking too much?" "Do you want to be less emotional or less upset or do you want to think about things less?"); and open-ended questions (e.g., "Why do you think that?" "How do you feel about that?" "What are your thoughts about coming to see me?").

*Hope and coping.* Certain additional codes from the CHANGE scale related to hope and coping were also used and coded by the four researchers as part of two related research studies. As these variables were all coded for the same five psychotherapy sessions simultaneously, the discussion section reflects comparisons made between these codes and the meaning-making codes as they were observed by the researchers during the coding process.

The CHANGE code that represented aspects of hope was the sense of hope scale. The sense of hope scale is defined in the CHANGE manual as "the person's capacity to see the possibility of change in the future, to recognize recent positive changes, and to express a commitment or determination to make changes" (Hayes & Feldman, 2005, p. 7). This sense of hope, or agency, was further broken down into both positive and negative hope. Positive hope was defined as "a feeling of movement or possibility, a commitment or determination to change" and negative hope was defined as "a feeling of being stuck, trapped, having no way out, sinking, feeling tired of trying, or a lack of commitment" (Hayes & Feldman, p. 7).

Because the existing CHANGE code captures the agency part of hope and misses out on the pathways part of it, an additional pathways scale was created from C.R. Snyder's emotive/cognitive hope theory, which is the most widely used and researched model of the hope construct in clinical psychology (Snyder, 2002). The hope pathways scale was defined as goal-directed thinking in which the individual perceives that he or she can produce desirable, realistic, and manageable routes or strategies to move toward the direction of present or future goals. This involves brainstorming options, planning ways to meet goals, and describing specific behaviors to perform. Pathways thinking was coded on a scale from 0 to 3 to maintain consistency with the CHANGE variables.

The CHANGE codes that represented aspects of coping were the content variable of relationship quality (positive and negative) and the process variable of protection/avoidance. Relationship quality was defined as how clients express their perceptions of interactions and relationships to individuals in their social encounters. Protection/avoidance measures forms of coping clients exhibit when having difficulty confronting disturbing thoughts, emotions or experiences (e.g., drinking to numb oneself; isolating behaviors; avoidance of therapeutic tasks; inappropriately laughing in session).

### Design

The study incorporated a combination of qualitative and quantitative content analyses of client expressions of meaning-making in the initial stages of the psychotherapeutic process, drawing on video-taped therapy sessions from an archival research database at a university's community counseling centers and clinics. The researchers grounded the study in a pragmatic paradigm, since it is believed that reality, or in this case the process of meaning-making, can only be understood imperfectly

(Haverkamp & Young, 2007). Because of this, multiple methods and investigations are required in order to identify knowledge via the convergence of findings (Creswell, 2003; Mertens, 2005). The qualitative methods used in this study were based on the content analysis work of Schilling (2006), Haverkamp and Young (2007), as well as the approach used by the researchers who developed and utilized the CHANGE coding system (Hayes, Feldman, & Goldfried, 2007). As stated above, the CHANGE scale (Hayes et al.) applied within the framework of the meaning-making literature review above, was used to gauge the frequency and intensity of clients' verbal expressions of meaning-making during psychotherapy, in an attempt to isolate and enumerate these statements.

There are a number of reasons the researchers decided to use a content analysis approach in this study. First, the researchers believe that assessing meaning-making is not something that can be achieved by using traditional quantitative instruments, which attempt to isolate variables from their broader context. Meaning-making is not something that exists in isolation; rather, it is dependent on certain experiences and processes that are constantly changing and re-influencing the experiences and processes themselves, similar to a feedback loop. In addition, the authors believe that the more research sheds light on the complexity between the interconnected workings of the mind-body, the more emphasis will be placed on qualitative research and its detailed observations of these complex processes at work. In a similar vein, content analysis is not bound to any particular theoretical assumption or psychotherapy orientation, and can, therefore, be used to analyze language expression in as unbiased a fashion as possible (Viney, 1983). As a method of analysis that can be unobtrusively applied to archival or live data, it provides a rich, complex perspective of the construct of interest (Schilling, 2006; Viney).



In addition, a number of researchers have argued that methods such as qualitative and quantitative content analyses of written and verbal material should be used in the study of psychotherapy, especially in the burgeoning area of positive psychology, which until recently has primarily relied on paper-and-pencil self-report questionnaires (Creswell, 1998; Flores & Obasi, 2003; Lopez & Snyder, 2003; Schilling, 2006).

The researchers' goal, then, was to better understand client expressions of meaning and how they are used by clients within the therapy process. This is something only an in-depth, contextually sensitive, qualitative design could provide. By using a "nonparticipation" (p. 382) form of qualitative observation of client meaning-making in psychotherapy, it was possible to observe the unique process and qualities of meaning-making as they occurred in this naturalistic setting (Mertens, 2005). At the same time, an empirically validated qualitative instrument helped the researchers identify and code for meaning across the whole therapy session. The CHANGE content analysis approach specified categories for analysis and allowed for potential modifications or additions to be made during the process. By better understanding the meaning-making process and its effects (e.g., what enhances it and what doesn't), researchers and clinicians can begin to better understand how change is occurring in therapy and what role, if any, meaning-making plays in it. By utilizing this approach, then, the researchers hoped to help generate ideas, grounded in the data, to further understanding of a poorly understood process.

#### Procedures

A purposeful sampling technique was used to create a pool of potential participants who met the inclusion and exclusion criteria mentioned above. All

participants were selected from a university's archival database which contained a complete list of de-identified clients who agreed to be included in the research database. When selecting participants, the specific client characteristics and demographics of age, gender, race/ethnicity, religious affiliation and presenting issues were considered in order to make sure that a representative sample of the counseling centers' population was obtained. We followed Creswell's (1998) recommendation to use extensive data collection methods and in-depth analysis for no more than four or five cases to optimize transferability and achieve a more detailed understanding of the processes being examined.

#### *Transcription*

Two master's-level psychology graduate students were recruited to transcribe the five participants' therapy sessions on a volunteer basis. The transcribers were first trained to criterion on an established transcription system, and then practiced transcription utilizing a 15-minute segment of a psychotherapy session from a professional psychotherapy training tape (the transcription system was adopted from Baylor University's Institute for Oral History; see Appendix C). After checking their work and adjusting for any discrepancies or problems, the researchers gave the transcribers access to video-taped therapy sessions so they could transcribe the sessions verbatim.

#### *Data Coding*

The coders consisted of three doctoral-level clinical psychology graduate students, and the research supervisor who is a psychologist. Coders were trained for approximately 4 weeks with 4 more weeks of practice coding to ensure criterion agreement (% agreement = .75; Hayes, Beevers, Feldman, Laurenceau, & Perlman,

2005). More specifically, the researchers attained percentage agreement of .84 prior to examining the actual psychotherapy sessions. Following practices utilized by Hayes et al. (2005), the specific ratings of all meaning-making variables obtained by coders for each session as a whole were averaged (once they reached .75 correlation after discussion) to be used in the analyses.

Training consisted of a number of factors: (a) education about the meaning-making construct (as defined by Park and Folkman as well as the other researchers' hope and coping constructs); (b) development of the coding manual (based on the CHANGE manual, Park and Folkman's definition of meaning-making, as well as the other researchers' hope and coping constructs); (c) modifications to the Change and Growth Experiences Coding Worksheet and the creation of a new, enhanced coding form (for recording frequencies, types of pathways expressed by each client, and types of relationships for the relationship quality code measuring coping, specific client statements coded as hope, coping, or meaning-making, and overall codes; see Appendix D); (d) the use of practice sessions to code sample tapes and transcripts in order to achieve high inter-rater reliability; (e) group discussions to compare codes obtained and to discuss differences to achieve better understanding of the constructs and increased inter-rater reliability; and (f) ongoing meetings to control for rater drift.

After the initial education about the constructs, the researchers discussed their individualized process of coding, including how they were reaching decisions on which individual meaning units or statements constituted a code (e.g., cognitive-emotional processing or unproductive processing) and what intensity level it should be coded as (none, low, medium, or high). When necessary, specific rules to be used in cases of

uncertainty were established (e.g., when only two examples of medium unproductive processing were noted throughout the entire session, it was to be assigned an overall code of low).

As the training process ensued, the researchers developed a greater understanding of the content analysis method. Coders witnessed firsthand the high level of inference inherent in the CHANGE content analytic system, even though it is structured and has empirical support. As a result, attempts were made to inhibit researcher bias and subjectivity as much as possible via frequent coder meetings and discussions of specific codes whenever there were differences among coders.

#### *Procedures Related to Human Subjects*

Informed consent and confidentiality of participant data was ensured throughout the study in a number of ways. First, all participants included in the research database consented to have their records included upon entering therapy at the university counseling center. Limits of confidentiality were discussed by each participant's respective therapist, and both verbal and written agreement was provided to permit review of their records for clinical and research purposes at a later date (see Appendix A for a sample client consent form). Second, all therapists included in the study consented to have their therapy tapes and client forms included in the research database (see Appendix B for a sample therapist research database consent form). Third, Institutional Review Board permission was sought and granted prior to accessing the research database. Fourth, prior to accessing any written, audio, or video records, each researcher completed an IRB certification course to ensure understanding and adherence to ethical human subject research. Researchers also completed online training on the Health

Insurance Portability & Accountability Act of 1996 (HIPAA), and signed a confidentiality agreement to access the research database. Fifth, all identifying information was removed from each participant's file and replaced with a research number to protect identities throughout the coding and data analysis process. Finally, the researchers created a list of all therapists known to them and, therefore, unable to be used in the selection of client videotapes. As a final precaution in order to preserve anonymity and reduce bias, a pre-screening of each tape was used during tape selection to ensure that coders did not know the therapists.

#### Data Analysis

Following the collection of data, all tapes were transcribed verbatim and reviewed for accuracy by the researchers. The unit of analysis for the coding of tapes was a full therapy session for each individual client included in the study, and the specific coding units were defined as themes or categories (Hayes et al., 2005). These categories represented the variables being assessed: cognitive emotional processing, unproductive processing and historical antecedents. As mentioned above, the categories of hope and coping were also assessed, with the same procedures applied to them as well.

After coders were trained to achieve % agreement of at least .75 on the various categories, they began the process of coding following the procedures for the CHANGE (Hayes et al., 2007). The authors of the CHANGE suggested reading the transcript or listening to the session while taking notes prior to coding the material (Hayes & Feldman, 2005). These procedures follow general guidelines for conducting research using qualitative and quantitative methods of content analysis of language (Schilling, 2006). Consequently, the coders, watched each video-taped session in its entirety, while taking

notes. They read each transcript one time through without coding, simply listening for the theme of meaning-making and taking notes. The researchers then read the transcript a second time and coded the entire session based on the definitions and methods aforementioned.

Afterwards, coders examined the transcript in detail at least two more times to look for specific meaning units, or client statements, to be coded for cognitive-emotional processing, unproductive processing, or historical antecedents. The length of meaning units varied and could consist of one sentence at a minimum, to as long as a paragraph, depending on the context of the verbalization (Hayes et al., 2005). When codes were found to apply to specific meaning units, they were rated on an intensity scale of 0 (not present or extremely low) to 3 (high). This additional step was utilized to gain a more detailed understanding of what types of statements appeared to constitute participants' expressions related to meaning-making. Afterwards, during coder meetings, the researchers would review each specific meaning unit they had coded and discuss it in depth until all four coders reached agreement on whether or not it should be coded and if so what intensity it should be coded as. This additional step permitted detailed documentation of each coder's thought process and helped limit progressive subjectivity during coding of each session (Creswell, 1998; Mertens, 2005).

Based on these methods, the final ratings obtained by coders for each session as a whole were averaged (once they reached .75 percentage agreement after discussion) to be used in the analyses. This rigorous coding process was utilized to improve the study's credibility, which is comparable to internal validity measures in quantitative studies (Mertens, 2005). Afterwards, coders discussed their areas of agreement and

disagreement, specific rules from the manual informing coding decisions for each meaning unit and for the overall session code, and observations noted from each session (e.g., client nonverbal behavior, client tone of voice during statements, and general interaction styles between client and therapist).

Following the team coding process, the primary researcher closely read through each transcript and all the data associated with it in order to examine clients' meaning-making statements within and across each unit of analysis (therapy session). Findings are presented below in the results and discussion sections through the use of common themes and meaning-making expressions in client statements. More specifically, the themes emerged from the data as the two primary researchers independently examined each of the clients' cognitive-emotional processing, unproductive processing, and historical antecedent statements, and assigned them with themes. They then qualitatively assigned the themes into groups of overarching themes based on each researcher's conceptualizations of the data. This process permitted detailed documentation of each researcher's thought process and helped limit progressive subjectivity during its completion (Creswell, 1998). The researchers then met at length to discuss each of the overarching themes. It was found that each researcher had come up with similar themes for grouping client statements. For variations in themes, the researchers explained their thought processes until 100% agreement was reached for the final number of themes to be used.

## RESULTS

This chapter presents the findings of the inter-rater reliability analyses along with reflections about researcher bias and the qualitative and quantitative content analysis. The content analysis concerns the following CHANGE codes: positive and negative historical antecedents related to early caregivers; positive and negative historical antecedents not limited to early caregivers; cognitive-emotional processing; and unproductive (repetitive) processing. As part of this analytic process, examples of participant expressions of these codes are presented and discussed. Finally, this chapter ends with a qualitative analysis of the aforementioned constructs, along with other CHANGE codes related to hope and coping (i.e., positive and negative hope, hope pathways, positive and negative relationship quality, protection/avoidance).

### Inter-rater Reliability

The percentage agreement among all four coders, both pre and post discussion meetings were calculated, and the results listed in Table 2. As indicated below, coders had an average pre-group discussion agreement of .85 for positive historical antecedents related to early caregivers, .80 for negative historical antecedents related to early caregivers, .85 for positive historical antecedents not related to early caregivers, .75 for negative historical antecedents not related to early caregivers, .75 for cognitive-emotional processing, and .60 for unproductive processing. In regards to post-group discussion, coders had an average agreement of 1.0 for all codes mentioned above, except cognitive-emotional processing, which had a post-group discussion agreement of .95.



Table 2

*Inter-rater Percentage Agreement Pre- and Post-Group Discussions Among Four Coders*

CHANGE Code	Pre-Discussion Average	Post-Discussion Average
Historical Antecedents – Early Caregivers Positive	85%	100%
Historical Antecedents – Early Caregivers Negative	80%	100%
Historical Antecedents –Non Early Caregivers Positive	85%	100%
Historical Antecedents –Non Early Caregivers Negative	75%	100%
Cognitive Emotional Processing	75%	95%
Unproductive Processing	60%	100%

In addition to determining the inter-rater percentage agreement amongst all four coders listed above, the researchers also decided to calculate the multiple-rater Cohen's Kappa coefficient ( $\kappa$ ). Cohen's Kappa is a frequently used measure of inter-rater reliability between coders within the qualitative research domain, especially when using a content analysis approach where the number of categories are few and the sample size is small (Uebersax, 2007). With Kappa, a  $\kappa > .70$  is considered acceptable inter-rater reliability, a  $\kappa$  of .40 to .59 is viewed as moderate, a  $\kappa$  of .60 to .79 is substantial and a  $\kappa > .80$  is considered outstanding (Mertens, 2005). When calculating inter-rater reliability for a set of items, as is the case here, mean Kappa is usually reported.

The average Kappa obtained for two of the meaning-making codes in this study (i.e., cognitive-emotional processing; unproductive processing) was .25 pre-discussion and .89 post discussion, implying fair, or less than moderate pre-discussion inter-rater reliability but excellent post-discussion reliability. Table 3 lists the Kappa scores obtained for each code as well as the average across codes.

Table 3

*Inter-rater Cohen's Kappa*

Change Code	Pre-Discussion	Post-Discussion
Cognitive-Emotional Processing	.22	.77
Unproductive Processing	.28	1.0
Overall	.25	.89

It should be noted that none of the four historical antecedent codes could be used in calculating Cohen's Kappa, due to the fact that there were not enough instances of their appearance within session material. Because most participants received scores of 0 or "N/A" for these categories, Kappa could not be calculated due to the lack of numerical data required to input into the Kappa equation. For these coding categories, then, only the inter-rater percentage agreements mentioned above were used to gauge their inter-rater reliability.

#### Researcher Bias

As with any research that is conducted, researcher bias exists. The primary researcher recognized his own bias early in the study. In this case, the bias manifested itself as a tendency for the primary researcher to code more participant statements as cognitive-emotional processing than did any other coder. Furthermore, the researcher also tended to more easily recognize and code the cognitive-emotional processing category, more than the other meaning-making codes being utilized in the study, as well as the other codes being utilized by other researchers. This could well have been due to the researcher's desire and expectations to find many instances of cognitive-emotional

processing during initial therapy sessions, in order to gather a lot of meaningful data and confirm his hypothesis.

Frequent group discussions and reliability checks with the other coders were used to control for this bias as much as possible. Doing so provided four different perspectives of the various constructs, which gave the researchers a more rich and complex understanding of them. As the group discussion took place, it became clear that the other researchers were experiencing similar biases as well, and also tended to identify and code more statements representative of the constructs they were examining, rather than the other researchers' constructs. In order to remedy this issue, coders discussed at length their rationale for selecting certain statements as representative of a particular construct, explained why a statement obtained a certain intensity code, and continually referred back to the manual in times of disagreement or uncertainty. This process eventually led to the refinement of the coding manual itself (e.g., having coders keep frequency counts for all constructs within a given therapy session, rather than simply providing only one overall code for the entire session as a whole) in order to provide more structure and greater understanding of the constructs being used, and a better means for resolving future coding uncertainties or disagreements.

#### Content Analysis

The findings of a content analysis for adult clients' language in transcribed psychotherapy sessions were as follows: for positive historical antecedents related to early caregivers, none of the participants produced any high or medium codes, 1 had a low code and the remaining 4 were coded as having none at all. The average rating among all participants was "none." For negative historical antecedents related to early

caregivers, the analysis produced 1 participant who scored high, another who scored low and the other 3 as having none. This resulted in an average rating of low. For positive historical antecedents not related to early caregivers, all 5 participants were coded as having none. For negative historical antecedents not related to early caregivers, 3 participants yielded a code of low and the other 2 were coded as having none; this resulted in an average rating of low. In regards to cognitive emotional processing, 4 participants were given codes of medium and 1 was given a code of low, resulting in an average code of medium. Lastly, the category of unproductive processing yielded 1 participant with an overall high code, 2 with medium codes and 2 with low codes, making for an average code of medium. Table 4 summarizes the data regarding the frequency and intensity of coded statements for each participant.

Table 4

*Number and Intensity of Participant Meaning-Making Statements*

H.A. Caregivers	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Positive					
High	0	0	0	0	0
Medium	0	0	0	0	0
Low	0	0	3	0	0
Overall Code	None	None	Low	None	None
H.A. Caregivers					
Negative					
High	0	0	4	1	0
Medium	0	0	2	1	0
Low	0	1	5	3	0
Overall Code	None	None	High	Low	None

(table continues)

	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
H.A. Non-Caregivers Positive					
High	0	0	0	0	0
Medium	0	0	1	1	0
Low	0	0	0	0	0
Overall Code	None	None	None	None	None
H.A. Non-Caregivers Negative					
High	0	0	0	1	0
Medium	0	1	3	1	0
Low	0	2	2	2	0
Overall Code	None	Low	Low	Low	None
H.A. Non-Caregivers Positive					
High	0	0	0	0	0
Medium	0	0	1	1	0
Low	0	0	0	0	0
Overall Code	None	None	None	None	None
H.A. Non-Caregivers Negative					
High	0	0	0	1	0
Medium	0	1	3	1	0
Low	0	2	2	2	0
Overall Code	None	Low	Low	Low	None
Cognitive-Emotional Processing					
High	1	2	4	0	0
Medium	5	2	11	10	10
Low	5	6	10	17	13
Overall Code	Medium	Medium	Medium	Medium	Low
Unproductive Processing					
High	0	0	2	5	0
Medium	3	0	4	5	0
Low	5	2	2	2	6
Overall Code	Medium	Low	Medium	High	Low

The subsequent section expands upon the quantitative data presented above and presents a qualitative description of participant statements. To better assist the reader in this process, a brief summary of each participant's demographic information and presenting problems is provided along with sample statements from each participant's session.

### *Participant 1*

The first participant was a 21 year old, divorced, Mexican-American, Pentacostal Christian female whose third session of therapy was used in this study. On the clinic intake form, she selected 33 primary presenting problems from a list, including, but not limited to the following, in no particular order: feeling nervous or anxious, feeling stressed, feeling angry much of the time, difficulty expressing emotions, lacking self-confidence, feeling unhappy, feeling lonely, feeling cut-off from her emotions, difficulty making or keeping friends, marital problems and family difficulties.

Participant 1 received an overall score of "none" for both positive and negative historical antecedents related to early caregivers, and also for positive and negative historical antecedents not related to early caregivers. She was given an overall medium code for both cognitive-emotional processing and unproductive processing. During the session, the client made 11 cognitive-emotional processing statements related to the following topics: religion, romantic relationships, coping with stress/anxiety, fitness, physical health, and education.

Out of these 11 statements, 1 of them was coded as high, 5 of them as medium and 5 of them as low. Specifically, the participant's high cognitive-emotional processing statement was:

And I think that's another reason why I stopped going to church, because I no longer wanted to use it as a crutch. I think it prevented me from growing in certain areas of, you know, my personality because you are dependent on that so much and that's...how I was taught. So, I guess now I'll just try and be realistic and think things through and that just the way it is.

Examples of the five medium cognitive-emotional processing statements she made included:

- “It’s just—well, I think I bottled everything up and the divorce—I really don’t think that I really processed everything because I was supposedly using, you know, the church based techniques that I really didn’t deal with it;”

- “Everyone would be really disappointed and upset” (said in response to the therapist asking her what would happen if she didn’t finish college);

- “Yeah, I know that’s part of the reason I probably get so sick often is because I’m not healthy. My immune system is low so I want to build that up and have more energy.”

Three of the five low cognitive-emotional processing statement she made included:

- “I guess I just kind of—got to the point where I was just tired of living my life according to what was politically correct according to the church—and so, I just got tired of it”;

- “But I mean, considering how I’ve just kind of been all over the place for the last year, it’s understandable I think” (referring to her absent-mindedness);

- “I think maybe it was just once I got married. Everything went downhill from there” (referring to her health and weight).

The participant made eight unproductive processing statements (three medium ones and five low ones) surrounding the topics of coping with stress /anxiety, romantic

relationships, perfectionism, and loss. The three medium unproductive processing statements the client made were:

- Maybe. I think at that point I was just so numb and [male friend] was being such a jerk that I [client shrugs] I mean I wanted the baby but then, at the same time, being realistic, I knew I couldn't really handle it. I mean I knew that I could have handled it if everything did go through and it would've worked out some way or another, but I knew it would've been tough;
- “But, I just, I think at that point I was just so numb emotionally that I just—just

kind of rolled it off my back;”

- And I—and I did it not 'cause a part of me wanted to, but a part of me already had gotten to the point where I just said it's over, but then there's that part of me that wanted to make him feel like he was—you know, that he had control over it a little—make him feel at least—make him feel like he actually had it for a moment...I'm not...I'm not sure [client scratches forehead].

Examples of the five, low unproductive processing statements the client made included the following:

- “So, it's sort of like it happened but it really didn't—like I really didn't really allow myself to—I don't know...it's kind of like I became cold towards it? I'm not really sure” (referring to how she handled her miscarriage);

- So it's special and I took it off to do dishes one day and I forgot to grab it, or I just—I can't remember if I forgot to grab it or if I grabbed it and put it somewhere else? I don't know—so I get mad at myself, it's like... [client sighs] (referring to losing the bracelet her boyfriend gave her and her tendency to lose things in general);
- I don't think it would have solved anything. I just would have cried and been upset over it. I just would have been upset and I don't see how it would have...I guess my mentality at that point was, you know, it really was for the best and... (referring to her miscarriage).

### *Participant 2*

The second participant was a 28 year old, single, African-American, male client who did not express a religious or spiritual orientation. The materials obtained from this



client were taken from his fifth therapy session. On the intake demographic form, the client indicated that he was seeking therapy for problems related to family difficulties, relationship problems, and feeling stressed/under pressure. In addition, the client reported a history of abuse, substance use, involvement in the legal system and a recent gunshot wound to the head. Because the participant left numerous questions blank on his intake paperwork, it is uncertain whether the information provided is a true account of his history, presenting problems and level of distress.

Upon completion of the coding for participant 2, he was given a code of “none” for positive historical antecedents related to early caregivers, and a code of “low” for negative historical antecedents related to early caregivers. The two specific client statements that were rated low both related to problems with his mother and her side of the family:

- “Like I said, my—my whole family on my mom’s side is out there. From my grandmother, all the way down to my aunts and cousins”;
- “Because she wasn’t working she probably couldn’t pay the rent or something...she was staying with various boyfriends and stuff like that—everyone worries about my mom a lot.”

In regards to positive historical antecedents not related to early caregivers, the client was given a code of “none,” and for negative historical antecedents not related to early caregivers he was given a code of “low.” The three specific statements made by the client, which included one medium and two low negative historical antecedents not related to early caregiver codes, were related to topics of environmental stressors and interpersonal relationships. The statement coded as medium was: “And then it ended up

real bad. She stole my truck, and stole the clothes out of the house...she went on stealing all kinds of stuff. Uh, it—it was real bad” (referring to his break-up with his ex-girlfriend). The two statements coded as low were:

- That’s when I first became instantly independent because my grandfather and my father was never really around, as far as, you know—as soon as I got home I had to discipline myself to make time to eat, make sure the door was locked, because you know I lived in a very gang active neighborhood...;

- “And I think as soon as my ex-girlfriend, who was the new girlfriend, moved in, uh, that’s when she kind of took a turn for the worse as far as our relationship...”

For the cognitive-emotional processing category, the participant obtained an overall code of medium, consisting of a total of 10 codes agreed upon by all coders.

More specifically, there were two high codes, two medium ones and six low ones, which fell in the following topic areas: romantic relationships, family issues, interpersonal relationships, and career/finances. The two client statements coded as high were:

- And that’s what turned me off to her, cause she, you know, she eventually wanted to come back and start talking—I just couldn’t do it because the way she acted...it reminds me of how my father and my mother was and felt like that whole ordeal...;

- Uh, the second time around I think it was worse because she couldn’t trust in me...like she never understood the ordeal that I went through with my ex—so it was always an issue. And so I think in the back of her mind it was already over, even though it had started up again, ‘cause she didn’t like that fact that my ex was a part of my life.

The two client statements coded as medium were:

- “Uh, I think that’s when the drug abuse became real serious, because I was going back and forth, just ‘cause I stayed out there...” (referring to his mother’s drug use);

- “When I first came, that’s when I first became instantly independent because my grandfather and my father was really never around...”

There were a total of six client statements coded as low, including, but not limited to:

- “Yeah, but it’s probably worth it in the long run” (referring to his new, second job and how little sleep he will be getting now);

- “He was more like a-a-a-uncle, as far as dealing with me, so it wasn’t like he was, you know, taking my father’s spot...he was more like just my mom’s boyfriend and my sister’s father;”

- “I never really wanted kids because when I was at that age, I would always think, to be a kid in this world is so hard and so long and...”

Finally, this client obtained an overall code of low for the unproductive processing category. This code consisted of three client statements coded as low, all of which fell in the romantic relationship domain. These statements were:

- Uh, it started off—like—I know she wasn’t relationship ready. So, it was more like just dating and me, I—I used to always tell her, I know you’re not ready for a relationship so, there would be a discussion about it, she would get upset... (describing his relationship with his ex-girlfriend);

- “Uh, I have—I have no idea why she—it really took me by surprise at how she started acting...” (referring to his ugly break up with his ex-girlfriend);

- “Uh, I have no idea. I know. I know we had started talking again, but she really wasn’t, really communicating” (referring to how he got back together with his ex-girlfriend).

### *Participant 3*

The third participant was a 25 year old, single, Catholic, Polish-American, heterosexual female. The materials used were taken from her third therapy session. On

her intake form, the client expressed the following primary presenting problems: nervousness and anxiety, concern about finances, concern about weight/body image, premarital counseling, and feeling stressed/under pressure.

Upon completion of the coding for this individual, an overall code of “low” was given for the category of positive historical antecedents related to early caregivers. There were three specific client statements, all coded as low and all in reference to either the client’s mother or parents in general:

- “But they were always very, very loving towards me and very much emphasized how important education was and how you can do anything you want in this country...;”
- “Mom was very—like very loving towards me and never critical and I think her mom was very critical and not as loving;”
- “Genetically I think I got some intelligence from them and on top of it, they always placed a high emphasis on it—but always about, you know, you are doing this for you, not for us.”

For the category of negative historical antecedents related to early caregivers, all coders agreed on an overall code of “high” for participant 3. This code was based on a total of 11 client statements (four high ones, two medium ones and five low ones). All related to family of origin difficulties, including: financial problems, poor parenting, alcoholism, abuse, and chaotic/negative environment. Client statements coded as high were:

- I guess she’s—I don’t want to say she’s crazy, but like she’s crazy (referring to her grandmother). So I worry about that ‘cause I’m, you know, I don’t want to sink into that either. You know my mom worries a lot and I worry a lot so...;

- “And I think one of the really big issues for me was—um—financial. Like we never had enough money...always getting kicked out of places...it was never stable like that. So I know that really affects me today;”

- “One of the main reasons I did so well in school was always because I would say to myself—I don’t want to live like this—I don’t want to live like my parents.”;

- “Vulnerable and frustrated—that’s how I used to feel, as like a child when I couldn’t do anything about it (her situation). Like I wasn’t able to have a job and I had to live with them and...”

The two specific client statements coded as medium were:

- “I’m thinking that I’m 25 now and my childhood—um—and upbringing, like it was really traumatic and all this relationship stuff too I guess...I’m thinking that its kinda time to either deal with it or not deal with it by get over it almost?”

- “I wonder to myself, have I forgiven my parents for all the things that I think they kind of messed up on?”

In regards to the category of positive historical antecedents not related to early caregivers, the client obtained an overall code of “none.” For the category of negative historical antecedents not related to early caregivers, the client received an overall code of “low.” This code of low, which was agreed upon by all coders, consisted of three client statements coded as medium and two coded as low. The specific statements all occurred in one of two topic domains: financial problems or romantic relationships. The three medium statements were:

- Thanksgiving was a big issue for us...his ex-wife is going to have Thanksgiving at her mom’s house—which is the girls’ grandma—and so that’s not somewhere I want to spend my Thanksgiving...and then the girls (daughters of the client’s boyfriend) made it into like he’s choosing between me or them;

- “She (referring to the daughter of the client’s boyfriend) came to me the other day and said like, ‘I know that my issues aren’t with you, it’s really with my dad.’

They’ve got all their issues about it;”

- “I think financially and coming from another country...I always kind of felt like I don’t belong at the table per se—or not part of the big group...”

Participant 3 was given an overall code of “medium” for the cognitive-emotional processing category. This code, which all coders agreed upon, was based on a total of 25 specific client statements, including 4 rated as high, 11 as medium and 10 as low. These statements were related to various contexts, including: career/work, family, romantic relationship, purpose, coping with stress/anxiety, education, finances, expectations for therapy and capacity to change. The four high cognitive-emotional processing statements made by the client were:

- And I think the more um, I don’t feel in control of my relationship or work...if I don’t have stability there, I think that’s where it gets—where I’m thinking about it more. When those things are in order, then I don’t think I have to control as much of all these other things...” (referring to cleaning her apartment in a particular way);
- I’m realizing how maybe I’m not seeing everything clearly—or I wonder what all my thoughts look like to the outside world. Um, I wonder if a lot of those things are holding me back...I’m thinking that it’s kind of time to either deal with it or not deal with it but get over it almost?” (referring to her traumatic childhood and upbringing);
- I wonder to myself, have I forgiven my parents for all the things that I think they kind of messed up on? And I think one of the really big issues for me was, um, financial—like we never had enough money, always getting kicked out, never stable—So I know that it still really affects me today...;

- “Just vulnerable and frustrated...like I used to feel as a child when I couldn’t do anything about it...” (referring to how she feels having gotten to a place of financial stability briefly, and then losing it again due to her relationship with her boyfriend).

Some examples of the 11 medium cognitive-emotional processing statements include:

- “I think I’m just meant to be here—like to do big things...I think I would have been limited in what I wanted to accomplish staying there (referring to her old job);

- “For me—somehow it’s not my coping mechanism (referring to alcohol). Food would be more my coping mechanism—sweets and sugar”;

- “I think he’s kind of never completely adapted to just becoming Americanized—like a part of him is still like very European” (referring to client’s father).

Examples of participant three’s statements that were coded as low in cognitive-emotional processing were:

- “I guess it’s a more creative way of thinking—you don’t have to go about things in a certain way...when you are almost kind of limited in a certain area, I think it just makes you more creative;”

- “Yeah I think we, I mean we are...in a little bit of a battle like that that for, for his attention;”

- “I guess, obviously, since I’m in this relationship, the side that thinks that it’s worth it is winning right now.”

In regard to the unproductive processing category, the client was given an overall code of “medium” by all coders. This decision was based on a total of eight statements the client made: two of which were coded as high, four as medium and two as low.

These statements were made in reference to the following topics: romantic relationship,

purpose, family, interpersonal relationships and work/career. The two unproductive processing statements coded as high were:

- “Um, it kind of sucks because I feel like I’m in a no win situation. Like, you know, I love this guy there’s all these great things, all this stuff I want to do with him...but if there’s so much negativity to take with that—to being in this relationship...so I don’t know...;”

- “And so, but this time it just feels kind of—like it’s really long and I can’t like break out of that (referring to the periodic re-evaluation she does of her life every six months or so, in order to figure out where she is and what she should be doing to get where she wants to go).

The four unproductive processing statements coded as medium were:

- “So I’m not sure if its cuz things are really bad or because maybe I’m thinking about it for the right reasons—I don’t know. I just argue in my head a lot;”

- “I wish I could tell” (referring to the therapist’s inquiry as to what perspective or side is winning in her head at the moment regarding what to do with her current relationship);

- “I kind of feel like right now I’m in a place where I can choose a lot of different things, so it’s like, kinda like this argument in my head, so it’s difficult to figure out in a sense (referring to her past and what to do about it);

- “Am I really depressed or am I not depressed? Am I just in a bad relationship? or I’m kinda struggling with that and I can’t really have a concrete idea of what exactly is going on...”



The two low statements were:

- “I’m not sure if he’s an alcoholic cuz he’s depressed or he’s depressed cuz he’s an alcoholic;”
- “I was able to pay all my bills and never had a problem, until, you know, I got into this relationship and now, like, I am a financial mess and I’ve paid all this money for his things and [client shrugs] so...”

#### *Participant 4*

The fourth participant was a 36 year old, divorced, Unitarian, Mexican-American female who was observed in the third session of therapy. She reported the primary reasons she was seeking therapy at this time were due to her difficulty in making and keeping friends, as well as the recent break up of her relationship. In addition, the client noted a number of secondary issues on her intake demographics form, including, but not limited to: feeling nervous/anxious, feeling angry, difficulty expressing emotions, lacking self-confidence, feeling lonely, marital/family difficulties and physical health concerns.

The client was given an overall code of “none” for positive historical antecedents related to early caregivers. She received an overall code of “low” for negative historical antecedents related to early caregivers, based on five specific statements: one was rated as high, one as medium and three as low. These statements were expressed in relation to one of the following topic areas: family of origin, alcoholism, and fitness. The one statement coded as high was: “I call it the divorce with my parents. I said, I’m not going to have you in my life anymore...and that was really traumatic.” The one statement coded as medium was: “Dave (client’s father) got a small business loan for ten thousand

dollars and he spent it all on cocaine. Uh, Ana (client's mother) ended up in the hospital again..." The three client statements coded as low were:

- "Mmhhh... (client responding affirmatively to the therapists asking if the client's parents were substance abusers all through her childhood);
- "And she's an alcoholic and she just had a stroke... (referring to her mother);
- "My parents would always tell me that, uh, if you become overweight no one will love you...that was a pretty consistent message."

The client was given an overall code of "none" for the positive historical antecedents not related to caregivers category, and an overall code of "low" for negative historical antecedents not related to caregivers. The overall code of low was agreed upon by all coders and consisted of four client statements; one was coded as high, one as medium and two as low. The statements were related to some of the following topics: alcoholism, fitness, and interpersonal relationships. The statement coded as high was: "That's been my entire life—I don't have any friends. All these people are common drinking buddies." The client statement coded as medium was: "I really recognize it's still with me to this day—that I don't know how to make friends in a non-formal environment." The two client statements coded as low were:

- "I drank a lot in college...and I don't really think I realized the consequences of partying until my senior year...;"
- "With the alcohol it was an escape...I felt sorry for myself—basically that I had to work and go to school."

For the cognitive-emotional processing category, the coders all agreed that the participant 4 made a total of 17 "low" intensity statements and 10 "medium" intensity

ones. However, even after discussion, one coder believed that the overall code for cognitive-emotional processing should be “low” rather than “medium.” The discussion revolved around the large number of “low” cognitive-emotional processing comments made, relative to the 10 “medium” ones and lack of any “high” ones, as well as the large number of “high” unproductive processing statements the client made within the same session. The other three coders who agreed on the overall code of “medium” cognitive-emotional processing felt that in order maintain the consistent coding style they had used up until then they needed to give an overall code of “medium” based on the fact that the client made so many medium and low intensity cognitive-emotional statements throughout the session (more than any previous participant who had received an overall code of medium). This led to a further discussion of whether a category, such as unproductive processing, should directly influence the rating of its “opposite”, cognitive-emotional processing. It was suggested that the categories and their opposites should remain completely independent of one another when considering how they are each to be coded, and that maintaining consistency with prior coding behaviors was very important to follow.

All 27 cognitive-emotional processing statements that the client made occurred within the context of the following topic areas: coping with stress/anxiety, interpersonal relationships, succeeding academically, work/career, family, physical health, romantic relationship, capacity to change, alcoholism, and finances. Some medium intensity cognitive-emotional statements made by the client included:

- “I’m learning that, um, people bring their stuff to every situation;”

- “It’s not what I want to be doing (referring to her therapy), but apparently it’s necessary...it’s blocking me from being happier. Maybe having a different attitude about a lot of things;”

- “I think becoming a teenager I—I went from sad to angry. And I realized that I—I wasn’t going to get what I needed from these people...”

The low intensity cognitive-emotional processing statements included, but were not limited to:

- “I guess I don’t want to do it (go to Al-Anon) because I think it’s just easy to sit around and bitch about things that used to happen—and why you think you have problems;”

- “You know, your work affects your personal, your personal affects your work;”

- “A lot of people can’t change;”

- “With the alcohol it was an escape.”

In regards to unproductive processing, participant 4 obtained an overall score of high, which all coders agreed upon. This score was based off of a total of 12 client statements, 5 of which were rated as high intensity, 5 as medium and 2 as low. All these statements were made in reference to one of the following topic domains: family, coping with stress/anxiety, succeeding academically, issues of control, physical health, and capacity to change. Some of the high intensity unproductive processing statements the client made were:

- “I think both of them (Al-Anon and ACA) serve a different purpose and...is ACA just an outlet for me to keep whining...or is Al-Anon where I need to be...I’m kind of torn;”

- “And how do I get off this loop in my head, you know? It just plays over and over again...” (referring to her past family history);

- “And then it just goes around to, well if I did it, why can’t they do it, you know? It just—it just goes round and round (referring to her parents’ inability to stay sober and straighten themselves out).

Some of the medium intensity unproductive processing statements made by the client included:

- “I try to tell myself that this is how it’s supposed to be—I’m supposed to feel this way...but I still beat myself up...” (referring to feeling stressed out and anxious about school;

- “Um, and then I have arguments with myself, but didn’t they want to learn?” (referring to her parents’ inability to take care of her);

- “But I don’t understand what exactly is wrong with me—if I have a chemical imbalance and if the depression is going to be there forever or if the anxiety is going to be there forever...”

#### *Participant 5*

Participant 5 was a 29 year old, single, Korean male with no reported religious or spiritual orientation. The materials used came from his third session of therapy. The client was self-referred for therapy after the death of a close friend. He reported 23 primary presenting problems on the intake demographic form, including, but not limited to: feeling nervous/anxious, afraid of being on his own, feeling inferior to others, feeling down/unhappy, experiencing guilty feelings, feeling confused much of the time, family difficulties, difficulty making/keeping friends, and use or abuse of drugs or alcohol.

The client received an overall code of “none,” which all coders agreed upon, for both the positive and negative historical antecedents related to early caregivers categories. The client was also given a unanimously agreed upon, overall code of “none” for both the positive and negative historical antecedents not related to early caregivers categories. In regards to the cognitive emotional processing category, the client received an overall code of “low.” This code, agreed upon by all coders, was comprised of 23 specific client statements: 10 were rated as medium intensity and 13 were rated as low intensity. All of these client statements fell into one of the following topic areas: romantic relationship, capacity to change, expectations for therapy, interpersonal relationships, loss, coping with stress/anxiety, self-esteem, and finances. Some examples of the 10 medium intensity cognitive-emotional processing statements the client made were:

- “I do want some sort of meaningful relationship, or something—that’s preferable;”
- “I’m sure just thinking about your problems—just kind of analyzing them helps get your mood up a little bit in general;”
- “Well actually that’s also part of the deflection I would say too—going to the gym, or riding my bike or jogging—I was not going out or trying to socialize, you know?”

Some of the low intensity cognitive-emotional processing statements made by the client were:

- “I’m trusting just because, I don’t, you know, uh—I think most people I know are relatively honest and stuff...so you know, there’s no real reason not to be trusting...well at least for the people I know;”

- “But there’s a lot of cultural pressures, I guess, that makes that behavior (referring to being frugal) unappealing...we’re in a commercial culture and there’s a lot of constant stimuli to spend, spend, spend, you know?”;

- “Uh, yeah, I do—I do actually. I see it as a courageous thing” (responding to therapist’s inquiry as to whether the client coming into therapy is perceived by the client as courageous or not).

For the unproductive processing category, participant five obtained an overall score of “low,” which was agreed upon by all coders. This score was based on six specific statements made by the client, all of which were rated as low intensity and occurred within one of the following topic domains: romantic relationship, substance abuse, expectations for therapy, self-esteem, finances and purpose. Examples of these low intensity unproductive processing statements made by the client included:

- And that also adds to the neuroses and makes it even more difficult I would say (referring to not having dated anyone for three years)...what am I supposed to do? Am I supposed to go online? And that’s kind of a blow to the self-esteem there too;

- “I’m pretty—relatively responsible, which is—and you can spin that bad too...well everything has a negative...it depends on the person, I guess, how you spin it, you know what I mean?” (referring to potentially good character traits in himself);

- “And maybe that’s why it works (referring to psychotherapy), because it’s just, uh, you’re active...”

In this case, especially, the coders all agreed that much of the client’s processing, or attempts at it, were continually undone by his questioning everything. It was almost as if the client was incapable of coming to a firm conclusion about anything and, consequently, was unsure about everything.

## Themes

This section presents the results of a qualitative analysis which was utilized to identify themes within and across participants. Next, the results of an analysis of themes across the various CHANGE codes are provided.

### *Themes Across Participants*

The researcher examined all participant statements indicative of cognitive-emotional processing, unproductive processing and historical antecedents, as well as the therapists' statements leading up to those coded participant statements. Themes that emerged for each client by code were then placed in Table 5. This information was used to identify patterns in the themes for each code across participants.

Table 5

### *Common Themes Observed Across Participants*

Cognitive-Emotional Processing	How Theme was Defined	Number of Participants
Questioning	Considering how one feels/thinks about some particular situation/experience in the present and/or past; asking oneself questions about a situation/experience (e.g., "is/was it this or that?")	5
Explaining	Coming up with some reasons as to why something is happening or did happen. It can be either present or past focused, but goes into more depth than simply reflecting on it in passing	5
Justifying	Convincing oneself that something is worth it/acceptable to do	5
Realization/Connecting past to present	Beginning to tie events from one's past to present in such a way that a new perspective/understanding begins to emerge about why one does what he/she does, or feels regarding something	5

(table continues)



Cognitive-Emotional Processing	How Theme was Defined	Number of Participants
Realization/Connecting past to present	Beginning to tie events from one's past to present in such a way that a new perspective/understanding begins to emerge about why one does what he/she does, or feels regarding something	5
Reflecting	Thinking about the past; reconsidering things in the past but only in passing, without going into much detail/depth	4
Attribution of Reason to Others	Coming up with assumptions as to why someone else did/does something in order to make sense out of it	3
Unproductive Processing	How Theme was Defined	Number of Participants
Uncertainty	Occurs when a person tries to examine some problematic situation/experience and understand it better, but is unable to do so for one reason or another. He/she might come up with one or two possible explanations for the problematic situation/experience, but is not confident in either's ability to explain it/provide resolution. No ruminative, obsessive or perseverative themes are present	5
Rumination	Tending to perseverate on some problematic situation/experience; ruminating continuously about it; considering many different possible reasons/explanations, none of which provide any resolution but, on the contrary, only lead to more rumination, uncertainty and distress	3
Positive Historical Antecedents Related to Early Caregivers	How Theme was Defined	Number of Participants
Parents Stressing Education	Parents expressing value of a good education	1 out of 1
Having Loving, Supportive Parents	Being loving, supportive toward child	1 out of 1 (same participant as above)

(table continues)

Negative Historical Antecedents Related to Early Caregivers	How Theme was Defined	Number of Participants
Parent Marital Difficulties	Having affairs; constant fighting/arguing	2 out of 3
Parent Substance Abuse Problems	Abusing alcohol/drugs on a continual basis	2 out of 3
Poor Parenting/Coping	Difficulty managing emotions effectively and inappropriately displacing them onto child/partner; physical/ psychological/ emotional abuse	2 out of 3
Parent Financial Difficulties	Constant financial difficulties; living in a poor/dangerous neighborhood; not much parental supervision due to parent having to work all the time	1 out of 3
Positive Historical Antecedents Not Related to Early Caregivers	How Theme was Defined	Number of Participants
Education/Work	Working hard in school; getting a good job where one can learn/grow	2 out of 2
Negative Historical Antecedents Not Related to Early Caregivers	How Theme was Defined	Number of Participants
Interpersonal Difficulties	Difficulty socializing with others/making new friends; difficulty managing relationship effectively	3 out of 3
Living in a Dangerous Neighborhood	Living in a dangerous/violent neighborhood with lots of crime and gangs	2 out of 3
Financial Difficulties	Having to work multiple jobs in order to make ends meet; never feeling financially secure	1 out of 3
Substance Abuse	Abusing alcohol/drugs as a means to escape from negative, overwhelming feelings	1 out of 3

*Cognitive-emotional processing.* For cognitive-emotional processing, six themes were discovered: Questioning; Reflecting; Explaining; Justifying; Realization/Connecting past to present; and Attribution of reason to others. More precisely, the themes were

defined in the following ways: (a) questioning involved considering how one feels/thinks about some particular situation/experience in the present and/or past; asking oneself questions about a situation/experience; (b) reflecting was thinking about the past; reconsidering things in the past but only in passing, without going into much detail/depth; (c) explaining had to do with coming up with some reasons as to why something is happening or did happen; it can be either present or past focused, but goes into more depth than simply reflecting on it in passing; (d) justifying involved convincing oneself that something is worth it/acceptable to do; (e) realization/connecting past to present had to do with beginning to tie events from one's past to the present in such a way that a new perspective/understanding begins to emerge about why one does what he/she does, or feels regarding something; and (f) attribution of reason to others entailed coming up with assumptions as to why someone else did/does something, in order to make sense out of it.

Four of these themes (questioning, explaining, justifying and realization) were present for all five participants, while the themes of reflecting and attribution of reason to others were present in four and three of the participants' sessions respectively. In regards to the theme of questioning, participant statements occurred in the following topic areas with the following frequencies: self-exploration 23% of the time; coping, family and therapy expectations each 15% of the time; and religion, romantic relationships, education and capacity to change accounting for the remaining 30%. For the theme of explaining, most participant statements occurred in the domains of romantic relationships (31%), self-exploration (19%), and coping (14%). The remaining statements occurred 7% of the time or less, in the following areas: interpersonal relationships, health/fitness, capacity to change, religion, work/career, education, family, finances, substance abuse,

and therapy expectations. Regarding the theme of justifying, most participant statements arose in the areas of interpersonal relationships (27%), romantic relationships (20%), and finances (13%), with the remaining statements occurring in the domains of religion, coping, work/career, education, purpose, and capacity to change. For the theme of realization, the majority of participant statements occurred in the categories: self-exploration (24%); romantic relationships (18%); family (18%); finances (12%); coping (12%); work/career (6%); substance abuse (6%); and capacity to change (6%). In reference to the theme of reflecting, most participant statements were found in the domains of family (30%), substance abuse (20%), romantic relationships (15%) and self-exploration (15%). The remaining statements occurred 5% of the time or less in the areas of coping, loss, health/fitness, and therapy expectations. Finally, for the theme of attribution of reason to others, participant statements occurred in only three categories: family (50%), romantic relationships (25%), and education (25%).

After examining all 5 participants' statements related to cognitive-emotional processing, additional observations were made by the primary researcher in order to determine the presence of other important patterns in the data. For example, even though the study's primary emphasis was on client language, therapist questions and statements preceding cognitive-emotional processing codes were also examined to see whether or not they had any noticeable effect on client statements. It was found that approximately 45% of the time, higher levels of cognitive-emotional processing by clients (medium or high ratings) occurred following open-ended questions by the therapist. Furthermore, it was found that empathic reflections by the therapist accounted for 16% higher level cognitive-emotional processing coded statements; tracking statements and direct

questions each accounted for about 12.5%; therapist advice/opinions represented 5%; psychoeducation and interpretation 3.5% each, and supportive comments just under 2%. Additionally, medium and high levels of cognitive-emotional processing occurred more than two-thirds of the time in the areas of romantic relationships, self-exploration, family and coping, and only one-third of the time in the domains of religion, work, education, finances, interpersonal relationships, substance abuse, loss, health, therapy expectations, and life purpose.

*Unproductive processing.* For the unproductive processing code, two major themes appeared to stand out from the participants' sessions: uncertainty and rumination. Uncertainty was defined as when a person tries to examine some problematic situation/experience and understand it better, but is unable to do so for one reason or another. He/she might come up with one or two possible explanations for the problematic situation/experience, but is not confident in either's ability to explain it or provide resolution. Rumination, on the other hand, was understood as the tendency to persevere on some problematic situation/experience (i.e., thinking continuously about it) without achieving any resolution or new insight/understanding.

Only the theme of uncertainty was present in all 5 participants' therapy sessions. The theme of rumination was found in 3 of the 5 participants' session material. In regards to the uncertainty theme, participant statements representative of it occurred in the following domains with the following rates: romantic relationships (24%); coping (21%); self-exploration (21%); substance abuse (10%); family (7%); finances (7%) and loss, purpose and therapy expectations approximately 3% each. When the theme of rumination was examined, most participant statements related to it occurred in the following

domains: family 47% of the time; self-exploration (27%); and romantic relationships, coping, loss and day-to-day activities 7% each.

Examining the effect of therapist statements on client responses, the primary researcher found that 58% of the time, higher levels of unproductive processing by the client (medium or high ratings) followed either an open or closed-ended question by the therapist (35% and 23% respectively). Therapist reflections and supportive comments each accounted for approximately 15% of higher level unproductive processing statements, while advice/opinions represented 8%, and psychoeducation 4%. Neither therapist tracking statements nor interpretations were present at all in higher level unproductive processing codes. Furthermore, these unproductive processing statements occurred more than 85% of the time within the domains of family, self-exploration and coping and less than 15% of the time in the areas of: religion, romantic relationships, work, education, finances, interpersonal relationship, substance abuse, loss, health, therapy expectations and life purpose.

*Historical antecedents.* For the historical antecedents code, there were various themes across the four separate codes, defined in Table 5. For the positive historical antecedents related to Early Caregivers' code, there was only 1 participant who received codes in this category. Out of participant 3's three statements, 2 fell under the theme of parents stressing education, while the other one had to do with having loving, supportive parents. The theme of having loving, supportive parents occurred in the following domains with these frequencies: mother (50% of the time); mother and father (50%). The theme of parents stressing education occurred solely in the domain of mother and father (100% of the time).

In regard to the negative historical antecedents related to early caregivers code, 3 of the 5 participants received codes for this construct. From these 3 participants' statements, four themes were discovered: parent marital difficulties; parent substance abuse problems; poor parenting/coping; and parent financial difficulties. All of these themes, except parent financial difficulties, were found in 2 of the 3 participants' statements. For the theme of parent marital difficulties, 100% of the statements occurred in the domain of mother and father. Regarding the theme of parental substance abuse, 40% of the statements occurred in the domain of mother and father; 40% occurred in the domain of father only, and 20% occurred in the domain of mother only. For the theme of poor parenting/coping, 43% of the statements occurred in the mother and father domain as well as the mother only domain, whereas only 14% occurred in the father only domain. Finally, 100% of the statements related to the theme of financial difficulties occurred in the domain of finances.

For the positive historical antecedents not related to early caregivers code, only 2 of the 5 participants made statements in this category, and both of them occurred within the theme of valuing education/work. One hundred percent of the statements related to this theme occurred in the domain of education/career. Finally, for the negative historical antecedents not related to early caregivers construct, 3 of the 5 participants received codes in this category. Participant statements reflected one of four themes: substance abuse; interpersonal difficulties; living in a dangerous neighborhood; and financial difficulties. The theme of interpersonal difficulties was found among all 3 participants, with 83% of the statements occurring in the domain of romantic relationships and 17% in interpersonal relationships. The theme of living in a dangerous neighborhood was found

in 2 participants' sessions, with 50% of the statements occurring in the domain of finances and 50% in the domain of family. The themes of substance abuse and financial difficulties were each found in only 1 participant's statements. For the theme of substance abuse, 67% of the statements fell in the domain of self-coping, and the remaining 33% in interpersonal relationships. One hundred percent of the statements related to the theme of financial difficulties occurred in the domain of finances.

When examining the effect of therapist statements on client responses, open-ended questions, direct questions and tracking statements each accounted for one-third of the therapist statements preceding client statements coded as positive historical antecedents related to early caregivers. For negative historical antecedents related to early caregivers, therapist influences were broken down in the following way: direct questions (46%), open-ended questions (24%), reflection (24%), and tracking statements (6%). Regarding positive historical antecedents not related to early caregivers, 50% of therapist statements preceding client statements were direct questions and 50% were tracking statements. Finally, for the negative historical antecedents not related to early caregivers code, the therapist influence was broken down accordingly: open-ended question (44%), reflection (21%), tracking statement (21%), direct question (7%), and interpretation (7%).

#### *Themes Across Other CHANGE Codes*

After qualitatively examining themes amongst participants in the meaning-making codes, the primary researcher looked for patterns that emerged across the other CHANGE codes. The largest overlap of individual CHANGE codes with the cognitive-emotional processing code was the protection/avoidance code, which co-occurred 23% of the time together. Cognitive-emotional processing also co-occurred with other CHANGE codes



with the following rates: positive hope 21%; pathways 15%; negative hope 11%; negative relationship quality 9%; negative historical antecedents not related to early caregivers 9%; negative historical antecedents related to early caregivers 6%; positive relationship quality 4%; and unproductive processing 2%. Neither of the positive historical antecedents codes co-occurred with the cognitive-emotional processing code.

In regard to unproductive processing, the CHANGE code that most often co-occurred within the same meaning unit, or very close to it, was the negative hope code, which measures hopelessness, feeling stuck, or lack of commitment/motivation. These codes co-occurred approximately 33% of the time together. Additionally, the unproductive processing code co-occurred with other CHANGE codes accordingly: pathways 20%; protection/avoidance 20%; cognitive-emotional processing 13%; positive hope 7%; and negative historical antecedents not related to early caregivers 7%. None of the remaining codes co-occurred with the unproductive processing code.

In regards to historical antecedent codes co-occurring with other codes, the following was discovered: (a) for positive historical antecedents related to early caregivers code, 50% of the time it co-occurred with the cognitive-emotional processing code, and 50% of the time it co-occurred with the positive relationship quality code; (b) for the negative historical antecedents related to early caregivers code, it co-occurred 58% of the time with the cognitive-emotional processing code, 33% of the time with the negative relationship quality code, and 8% of the time with the unproductive processing code; (c) for the positive historical antecedents not related to early caregivers code, it co-occurred 100% of the time with the cognitive-emotional processing code; and (d) for the negative historical antecedents not related to early caregivers code, it was found to co-

occur 57% of the time with the cognitive-emotional processing code, 29% of the time with the negative relationship quality code, and 14% of cases with the unproductive processing code.

## DISCUSSION

The study examined meaning-making statements among adult clients at a university's community counseling centers during the third to fifth sessions of individual psychotherapy. Although there is an extensive quantitative literature base on meaning-making, few studies have taken a qualitative approach to researching this critical construct in the therapy context. Consequently, this study aimed to enhance our understanding of the meaning-making process; how it is created, influenced and manifested by individuals in therapy, by incorporating qualitative examination of actual client language, as well as therapist utterances immediately preceding client statements. In performing this work, the researcher used the current literature on meaning-making to inform content analytic coding with the Change and Growth Experiences Scale's (CHANGE; Hayes et al., 2007) cognitive-emotional processing, unproductive processing and historical antecedents codes.

To answer the research questions of how adult clients expressed meaning during intake sessions at a university community counseling center, and the major processes they used when doing so, this chapter provides a summary and discussion of codes and themes observed across participants and other CHANGE codes. First there is a discussion of the results of the content analysis conducted with the modified CHANGE coding system, including modifications made to it prior to coding and proposed modifications for future measurement of meaning-making as a construct. Second, a summary and discussion of common themes observed across participants as well as other variables coded by the research team (i.e., hope and protection/avoidance) is presented. Third,

methodological limitations are examined. Finally, potential contributions of the present study and future directions are explored.

### Content Analysis Results Using Modified CHANGE Coding System

#### *Content Analysis*

The results of the content analysis for the five psychotherapy sessions revealed no overall codes of high intensity for any of the meaning-making CHANGE codes examined. The average scores across all 5 participants were as follows: “medium” for cognitive-emotional processing; “medium” for unproductive processing; “none” for positive historical antecedents related to early caregivers; “low” for negative historical antecedents related to early caregivers; “none” for positive historical antecedents not related to early caregivers; and “low” for negative historical antecedents not related to early caregivers.

The overall score of “medium” for the unproductive processing code fits with common sense thinking, as many clients come in for therapy when they are experiencing some form of negative affect due to difficulties in their lives and seek out therapy as a means of helping to resolve what is upsetting them at that moment. Our findings of seeing a greater frequency of unproductive processing in the initial stages of therapy, manifested through the themes of rumination and uncertainty is consistent with the literature. Positive associations between self-rumination (dwelling on the negative in relation to the self) and depressed mood are widely supported (Nolen-Hoeksema, McBride, & Larson, 1997; Nolen-Hoeksema & Morrow, 1993). In addition, meta analyses have linked rumination with anger, anxiety, embarrassment, helplessness, stress and negative mood in adults (Thomsen, 2006). Also, uncertainty, considered to be “an

aversive state that people are motivated to reduce,” tends to amplify and prolong negative affective reactions to negative events by impeding people’s understanding of why something happened and how the event/experience fits into their world view (Bar-Anan et al., p. 123). Yet, uncertainty may not always lead to negative outcomes. Bar-Anan et al. posit that uncertainty increases people’s curiosity regarding some event or experience, thereby increasing the amount of attention paid to it and the resulting perception or feeling of being emotionally engaged with it.

The overall score of “medium” for the cognitive-emotional processing code suggests that these clients also used language for creating new meaning. Rather than being completely separate and independent processes, our results indicate that cognitive-processing and unproductive processing may co-exist on clients’ meaning-making spectrums in the initial phase of therapy. In fact, there were a number of instances in which both cognitive-emotional processing and unproductive processing were coded together in the same coding unit. Supporting this view, Elliot and Coker (2008) suggest that self-rumination may be a by-product of self-reflection and one’s inability to disengage from that process in the midst of negative events in one’s life. At the same time, although uncertainty can be involved in one’s inability to disengage, it can also increase one’s attention and emotional engagement, which could foster cognitive-emotional processing (Bar-Anan et al., 2009). Therapists, then, are challenged to assist their clients in finding a balance in which the process of self-reflection does not spin out of control - leading to rumination and distress/negative affect - but is properly managed or controlled so as to lead to greater meaning-making and proper resolution of the reflective process.

In regards to the historical antecedents codes, the overall score for both positive codes (positive historical antecedents related to early caregivers and positive historical antecedents not related to early caregivers) was “none or N/A” and the overall score for both negative codes (negative historical antecedents related to early caregivers and negative historical antecedents not related to early caregivers) was “low.” These findings again mesh with common sense thinking that clients entering therapy are likely experiencing some negative affect, and may be more likely to recall, think about, and/or focus on negative experiences more than positive ones. The research also suggests that people who are experiencing rumination and uncertainty (in concert with avoidance, which is discussed below) may be hindered in their ability to focus on alternative, more positive interpretations of events or experiences (Kashden & Breen, 2007). Because social connectedness and positive engagement with others (family, friends, peers) has been found to be a vital part of a meaningful life, whereas perceived alienation from others and the world has been indicated as a leading contributor of meaninglessness in one’s life (Cacioppo et al., 2005; Debats, 1999; Mascaro & Rosen, 2005), therapists should consider assessing the quality and degree of each client’s social support and, where lacking, help him/her develop skills in order to create new ties and/or strengthen existing ones.

#### *Modifications to CHANGE Codes*

As discussed in the literature review, defining and measuring the construct of meaning-making is a complex task given differing definitions and measures throughout the literature. To better understand meaning-making through qualitative analyses with psychotherapy clients, we used the only qualitative measure we could find in the

literature which attempted to measure meaning-making with this population, the Change and Growth Experiences Scale (CHANGE; Hayes & Feldman, 2005). We chose the CHANGE codes of cognitive-emotional processing, unproductive processing and historical antecedents related to early caregivers, because we felt each code captured a component of either meaning-making itself or its opposite. Meaning-making has been referred to in the literature as cognitive-emotional processing (e.g., Park & Folkman, 1997) and we felt that the CHANGE's cognitive-emotional processing code attempted to directly capture the meaning-making process. The historical antecedents related to early caregivers' code was selected in order to capture influence of past and present social interactions with others' on the meaning-making process (Cacioppo et al., 2005; Debats, 1999; Mascaro & Rosen, 2005). Finally, we included the CHANGE's unproductive processing code, which we thought would reflect the antithesis of cognitive-emotional processing, as a way to examine the factors that might hinder clients' ability to make meaning.

Before CHANGE coding began, modifications were made to the codes and the process. First, we changed the time frame for each coding unit, which originally was an entire therapy session. Feeling that much valuable information would be lost in the process of simply assigning a global code to each therapy session, the researchers decided to modify the CHANGE coding system so that each coding unit could be as brief as a sentence. We felt this change provided a fuller understanding of the complex interaction effects between cognitive-emotional processing, unproductive processing, historical antecedents and other CHANGE codes. Also, it provided better insight into how each person was conceptualizing each coding construct, which allowed for much richer

discussions and increased understanding during coder meetings as well as increased inter-rater reliability among coders.

Another enhancement made to the CHANGE included the addition of another historical antecedent coding category. The reason for this addition was that we felt the original CHANGE code of historical antecedents (related to early caregivers) attempted to capture the influence of powerful early experiences (either positive or negative) with parents or early caregivers, but neglected other potentially powerful, past-influencing experiences with friends, partners, peers, relatives, and other significant people in the clients' lives. Because the literature suggests that social interactions/connectedness impact one's level of meaning in life (Cacioppo et al., 2005; Debats, 1999; Mascaro & Rosen, 2005), we felt it necessary to add another historical antecedents coding category (not related to early caregivers) in order to capture those potentially powerful influencing events/experiences from one's past.

In addition, we further clarified how each code should be scored (low, medium, high, not applicable) by including more written examples of each coding level. We found that this modification to the CHANGE manual greatly improved inter-rater reliability for coders by helping them better understand the types of statements they should be coding. Finally, we kept track of the various types of questions therapists asked and the topic domains in which coded client statements were occurring, in order to help provide more insight into the factors impacting clients' meaning-making processes.

#### *Proposed Modifications for Future Measurement of Meaning-Making as a Construct*

Our decisions to reduce the size of each coding unit from an entire therapy session down to a sentence, to broaden the historical antecedents code to include people other



than caregivers, and assess other domains were beneficial, but not sufficient for fully grasping all the variables involved in meaning-making for clients. Going forward, we offer the following recommendation in order that researchers might better capture the complex process of meaning-making.

Future studies examining the process of meaning-making in clients should consider using a moment-by-moment microanalysis of both client and therapist verbal and non-verbal behaviors in order to better understand the meaning-making process, and various factors impacting it. As a social process, meaning-making during therapy involves the inter-subjective dance that occurs between therapist and client during sessions. Because non-verbal information (e.g., eye movements, changes in facial muscles, breathing patterns, body posture/movements) is being transmitted continuously, it should be measured continuously, instant-by-instant, to decipher the complex non-verbal dance taking place between therapist and client, and how that dance impacts meaning-making for the client. Then, the non-verbal information should be compared with the verbal information being exchanged between therapist and client to see if it is congruent or incongruent. As part of this process, future studies should more fully examine therapists' ability to empathize, reflect and validate their clients given our hypothesis that therapists' ability to convey Roger's necessary and sufficient conditions for client change (empathy, unconditional positive regard, congruence) is directly associated with client meaning-making (Rogers, 1961; Wampold, 2001).

At the same time, a contextual perspective should not just apply to studies of the therapy context, but to all situations where one is attempting to create meaning in life with the assistance of others. As human beings are social creatures and are apparently

influenced to a strong degree by social pressure and interactions, one cannot neglect this powerful influencing factor when attempting to understand how meaning is made. Thus, existing and future measures of meaning-making should include a scale dedicated to understanding both past and present positive and negative social experiences with others in all areas of one's social life (e.g., family, friends, work, peers).

Similarly, we recommend that future studies attempt to break down and assess meaning in its various forms by examining meaning in the various domains of people's lives. Wong (1998) found that meaning tends to emerge from eight sources in people's lives: achieving valued goals; engaging in self-transcendent activities, perceiving a rough degree of fairness in the world, accepting one's limitations; engaging in intimate emotional relationships with others, being sociable and well liked; having a relationship with a higher power; and experiencing positive emotions. Future research could further examine Wong's sources in qualitative examination of therapy sessions, which could lead to the design of a self-report measure that incorporates these domains. Therapists could also consider inquiring into these domains when working with clients in psychotherapy to help them examine aspects of creating meaningful lives for themselves.

## Themes

### *Themes Across Participants*

This section discusses the themes that were qualitatively observed across the 5 research participants pertaining to the cognitive-emotional processing and unproductive processing codes. No themes are presented across historical antecedents codes because there were too few statements within and across each coding category to properly establish any themes across participants.

*Cognitive-emotional processing.* There were a number of common themes discovered across participants in their expressions of cognitive-emotional processing during psychotherapy sessions. Four themes that emerged in all 5 participants' therapy sessions were: (a) questioning; (b) explaining; (c) justifying; and (d) realization. Other themes that were discovered included the theme of reflecting, which was found in 4 out of the 5 participants, and the theme of attribution of reason to others, which appeared in 3 out of the 5. In terms of trying to determine which themes were more effective than others in facilitating the meaning-making process, we found the theme of realization accounted for 63% of statements coded as "high" cognitive-emotional processing, along with 18% of statements coded as "medium;" whereas the theme of explaining accounted for 43% of "medium" rated cognitive-emotional processing statements, and 40% of "low" rated statements. Finally, the theme of reflecting represented 24% of the overall statements coded as "low" cognitive-emotional processing.

These findings are congruent with the literature on meaning-making and how rumination and uncertainty impede its process and resolution. Research indicates that the presence of runaway self-reflection, in the form of self-rumination, hinders happiness and resolution of the meaning-making process. Lyubomirsky (2001) has found that happy people are less prone to engage in self-reflection, or to think about and analyze their thoughts, feelings and outcomes of their actions. Furthermore, the more they were made to self-reflect, the more their behaviors matched those of unhappy people; whereas unhappy individuals who were prevented from engaging in self-reflection displayed behaviors similar to those of happy people (Lyubomirsky & Ross, 1999). As seen in our study, the theme of realization, which has to do with connecting past and present events

together in such a way as to gain new insight and understanding into some experience or event, entails less rumination and uncertainty than the themes of reflection or explanation, which entail less certainty and more consideration of many potential reasons or contributing factors.

The cognitive-emotional processing themes tended to occur most often in the domains of family, romantic relationships, interpersonal relationships, coping and self-exploration across all 5 participants. These findings mesh with the literature mentioned above, which suggest that social connectedness and engagement with life/others plays a crucial role in the creation of a meaningful life (Cacioppo et al., 2005; Debats, 1999; Mascaro & Rosen, 2005).

Cognitive-emotional processing statements made by participants, most often occurred after an open-ended question was posed by the therapist (45% of the time), or following an empathic reflection (16% of the time), tracking statement (12.5%) or direct question (12.5%). These results are in accord with the literature, which suggest that clients are less resistant and make more progress in therapy with therapists who take a more nondirective approach (i.e., asking open-ended questions and making statements that indicate support, understanding or encouragement for the client) when interacting with clients, than with those who take a more direct approach (i.e., challenging/confronting the client; making statements which lead or direct control of the verbal activity of the therapy session) (Bischoff & Tracey, 1995; Elkins, n.d.). More specifically, open-ended questions are thought to help facilitate increasingly accurate understanding, problem-dissolving, and solution-generating behaviors that help clients get better, when compared to any other form of question asking (Boyd, 2003). Indeed,

clients have endorsed the suggestion that one of the most important aspects of a successful therapy experience is the way the therapist asks questions (Anderson, 1997).

Curiosity and respect play key roles in posing questions to clients. Open-ended questions help create an open space for the client's own words and narrative imagination in a way that facilitates a process of ongoing understanding of his/her reality, instead of having one simply imposed by a more directive therapist (Boyd, 2003). This nondirective approach suggests, then, that giving clients the space and freedom to come up with their own meaning, rather than making interpretations or taking a more direct approach, may lead to greater opportunities for the meaning-making process to flourish. Taking this nondirective stance with clients may indirectly send the message that therapists are interested, that they care and are listening carefully, and that clients should continue on with their narrative, trusting in their self-actualization potential (Rogers, 1961).

*Unproductive processing.* In regards to the unproductive processing code, two themes emerged from the data across the participants. They included the theme of uncertainty, which appeared in all 5 participants' sessions, and the theme of rumination, which appeared in three out of the five sessions. In terms of which theme contributed more towards higher levels of unproductive processing, it was found that 67% of "high" unproductive processing statements fell under the theme of rumination, whereas 58% of "medium" and 84% of "low" unproductive processing statements occurred within the theme of uncertainty.

The literature on uncertainty fits nicely with the results of the present study, as it appears to be one of the primary hindrances of meaning-making. It is thought that the

quicker people understand an event or experience (i.e., why it occurred and how it fits into their self-concept and world view), the more quickly they adapt to it and move on with their lives (Wilson & Gilbert, 2008). Therefore, anything which impedes understanding of some event or experience will usually prolong the affective reaction to it and, therefore, serve as an amplifying force, regardless of whether it is a positive or negative experience (Bar-Anan, Wilson, & Gilbert, 2009). This amplification process is believed to occur through increased attention and curiosity towards some event or experience, which uncertainty motivates, thereby making a person more emotionally engaged with it (Wilson & Gilbert).

Uncertainty is also thought to have both an informational component (a deficit in knowledge) and a subjective component (a feeling of not knowing) (Smith & Washburn, 2005). The state of uncertainty is considered to be dynamic and ever-changing, depending on one's perception and processing of evidence, along with levels of perceived confidence and control over the event/experience. Furthermore, different types of uncertainty exist, depending whether the doubt is situational or existential in nature (Penrod, 2007).

One example of uncertainty at work can be seen in some of participant 4's statements. At one point participant 4 was trying to figure out why her parents, whom she called "alcoholics" and described as inept at parenting, did not try and better themselves like she was doing presently. She stated:

I've thought about it a little bit, because you know it gets in there while I'm trying to read and stuff...just the argument about well you didn't know how to love me, but why didn't you want to learn?...and then just thinking about it because I have so much to do...and uh, angry that I have to spend time on this now...it's not what I want to be doing, but apparently it's necessary—it's

blocking me from being happier...and how do I get off this loop in my head, you know?

This example illustrates Bar-Anon et al.'s (2009) amplifying force of uncertainty as well as its link to rumination. Because this client was unable to understand why her parents did not try and get help in overcoming their alcoholism, in order to be better parents to her, she continued to be plagued by uncertainty, which led to her experiencing negative affect in the form of anger and frustration and to a cycle of rumination that she feels she is unable to escape (i.e., the "loop" in her head).

The ruminating literature parallels the uncertainty literature in a number of ways. First, just like uncertainty, rumination, or the act of repeatedly thinking about an emotional event, maintains and/or amplifies a person's emotional response to it (Morrow & Nolen-Hoeksema, 1990). Additionally, rumination is characterized by negative evaluations combined with perceived uncontrollability (Rude, Maestas, & Neff, 2007). Furthermore, a tendency to ruminate is associated with longer-lasting depressive symptoms and more frequent depressive episodes (Ray et al., 2008). Although not examined in the present study, the literature also contains considerable evidence indicating that the way in which a person thinks about events shapes his/her emotional responses to it (Rude, Maestas, & Neff) and that changing how one thinks about life events can directly affect both emotional and physiological responding in that individual (Ray, Wilhelm, & Gross). An implication of this literature for therapists is to help clients consider new ways to think about and integrate their learning about an event/experience, instead of focusing on how an event makes them feel. Creating a stronger sense of self control and confidence over the situation can reduce uncertainty and the ruminative process.

The present study also found that unproductive processing statements occurred most often after therapists posed open-ended questions (35% of the time), direct questions (23% of the time), reflections (15% of the time) and supportive comments (15% of the time). Open-ended questions were the most frequently observed influencers for subsequent unproductive processing statements made by clients, just as they were for cognitive-emotional processing statements. This was an unexpected finding, which appears to go against what the literature says on the value of open-ended questions over direct questions in facilitating the meaning-making process. Although not examined in the current study, one possible explanation for this finding could be that, although the therapist was asking open-ended questions, the manner in which he/she was doing so may have been received by the client in a more disrespectful/uncaring way via the therapist's non-verbal behaviors. Future research should examine therapists' verbal and nonverbal behaviors. An additional way of making sense of this finding might be the previously mentioned observation that both cognitive-emotional processing and unproductive processing appear to fall on the same continuum.

However, it is also noted that direct questions posed by the therapist accounted for almost twice the rate of unproductive processing statements than they did for cognitive-emotional statements. Some evidence indicates that the nature of the therapist's directive behavior (e.g., tentative vs. absolute) may influence the client's response (Jones & Gelso, 1988). Another possible explanation might be that different clients require different therapist approaches depending on such client factors as personality characteristics, presenting problem, levels of motivation, self-concept, and the degree of uncertainty or rumination presently being experienced (Hubble, Duncan, & Miller, 1999). For example,



Beutler et al. (as cited in Hubble, Duncan, & Miller) found that therapist directiveness was more helpful in working with clients he described as resistant-prone and depressive than it was with their low resistant counterparts. Other findings suggest that taking a more exploratory approach with clients works best with individuals who are highly motivated and have coherent self-concepts; whereas a more supportive approach works best with clients who are less motivated and have unstable self-concepts (Horowitz et al., as cited in Hubble, Duncan, & Miller).

There is also some indication in the uncertainty literature that the type of uncertainty a client is suffering from (situation or existential) should guide the therapist's resulting intervention. More specifically, the provision of information by therapists was found to be most helpful in reducing situational modes of uncertainty; however, it was not helpful but rather harmful when attempting to reduce existential uncertainty because it contributed to increased feelings of being out of control and challenged one's confidence in being able to assimilate information properly (Penrod, 2007). Therefore, depending on the form of uncertainty being experienced by the client, strategies may focus on personal introspection (for existential uncertainty) or a more cognitive processing of available information (for situational uncertainty). Penrod suggests that the overall goal, then, is to help facilitate client movement towards a state of minimal uncertainty, where his/her sense of confidence and control is maximized.

#### *Themes Across Codes*

Turning our attention towards examining various themes across CHANGE codes themselves, for cognitive-emotional processing, the other CHANGE codes which most often occurred within the same coding unit, or immediately before or after it, were the

protection/avoidance code (23% of the time) used to assess the construct of coping and the positive hope code (21% of the time) used to assess the construct of hope. By including the pathways code (another aspect of hope), which co-occurred 15% of the time with cognitive-emotional processing, then 36% of the time cognitive-emotional processing co-occurred with some aspect of positive hope (either agency or pathways).

Throughout the coding process, the coders would often comment on the frequency with which cognitive-emotional processing and positive hope co-occurred, and the collected data supported our initial observations. These findings are in line with the relevant literature on meaning and hope, which find strong associations between the two constructs (Mascaro & Rosen, 2005). Some researchers go so far as to suggest that hope is a vital component of life meaning, since hope is a goal directed thought process and meaning is, in essence, the source of important life goals (Feldman & Snyder, 2005). As the active cognitive process of moving people towards their life goals, hope, via agency (goal directed motivation) and pathways (planning to meet goals), thereby, creates meaning and purpose in people's lives (Feldman & Snyder; Michael & Snyder, 2005).

In addition to theoretical support for the relationship between meaning and hope, there is also empirical evidence. In a longitudinal study of a non-clinical, young adult population, Mascaro and Rosen (2005) found that individuals with high levels of meaning tended to have fewer symptoms of depression, were more characterologically hopeful and experienced more hopeful states than individuals with lower levels of meaning. Therefore, for those who view their life as meaningless, training in hope may prove helpful as an adjunct for traditional existential psychotherapies (Mascaro & Rosen).

Regarding the protection/avoidance code (one of the codes for the construct of coping), it was defined in the CHANGE measure as an attempt to protect or defend oneself by pulling away from rather than moving toward problems or issues (Hayes & Feldman, 2005). Based on this definition and the fact that this study utilized the initial stages of therapy sessions in its analysis, a time when clients may be experiencing distress and coping with that distress using avoidant techniques, it makes clinical sense that we found high rates of protection/avoidance exhibited by our participants.

But the discovery that protection/avoidance co-occurred with cognitive-emotional processing (when the codes appear at first glance to be more opposite than similar) was less expected. At the same time, however, because confronting one's issues/problems is never an easy, enjoyable task to perform, one might assume that there would be a greater incidence of protection/avoidance co-occurring with "low" levels of cognitive-emotional processing, rather than medium or high levels. When one is beginning the process of meaning-making, he/she is more hesitant and uncertain about examining new problem areas, rather than ones which are older and more familiar. This assumption is supported by the data in this study, which indicated that the majority of co-occurring protection/avoidance and cognitive-emotional processing was during times of "low" cognitive-emotional processing by the clients.

The literature on resistance also assists us in better understanding the relationship we found between avoidance and cognitive-emotional processing. In this sense, resistance can be defined as any behavior that indicates overt or covert opposition to the therapist, counseling process or therapist's agenda (Bischoff & Tracey, 1995). There is some indication that resistance may, in fact, be a healthy part of therapy and push clients

in the direction they need to go. Successful therapy dyads show increases in resistance levels by middle stages of therapy, whereas unsuccessful dyads do not (Tracey & Ray, 1984). Similarly, another study found that low resistance levels in clients corresponded with negative therapy outcomes (Tracey, 1986). Since there is also general agreement that relatively high levels of resistance are a negative indicator in therapy (Bischoff & Tracey), these findings suggest that there may be an upper and lower bound, within which resistance is positive in therapy and indicates that the work of therapy is occurring (Tracey). In addition to looking at global levels of client resistance in therapy, it also appears valuable to examine micro-level interactions between clients and therapists. Hill, et al. (1992) found that clients rated therapist behavior as most helpful when it was subsequently followed by highly resistant client behavior.

When examining the present findings through the lenses of this literature, it makes sense that cognitive-emotional processing and protection/avoidance (resistance) would co-occur. The process of examining/reflecting on past events/experiences may, at times, lead one to instinctively try and avoid/resist the potentially powerful feelings that doing so would bring forth. One might conceptualize this process as a type of dance, where the client begins to reflect and cognitively process material and then, once it begins to get too frightening or overwhelming, he/she pulls away briefly, only to return again in order to continue on with the process of finding meaning and resolution.

Regarding the unproductive processing code, it was found that it co-occurred most frequently with the negative hope code (33% of the time) and the pathways and protection/avoidance codes (20% of the time each). Based on what was mentioned previously about the strong relationship between hope and meaning, the literature

supports our finding that there was a strong co-occurrence of their opposites, unproductive processing (lack of meaning) and negative hope/pathways (lack of hope). Similarly, our finding that pathways co-occurred most often with unproductive processing is understandable when viewed through the lens of the ruminating/uncertainty literature, which has found that having too many options/choices to act upon something can be just as paralyzing/immobilizing as having none, and leads to rumination/uncertainty and its associated negative affective states (e.g., sadness, depression, anxiety, anger) (Iyengar & Lepper, 2000; Schwartz 2004; Schwartz et al., 2002).

Regarding protection/avoidance, it is a well understood aspect of human nature that people are motivated to escape unwanted, negative self-directed thoughts and feelings about themselves and may, often, engage in avoidant or escapist behaviors to eliminate their self-awareness; thereby temporarily reducing the psychological pain associated with that reflective process. It follows, then, that when an individual already in a fragile, uncertain state is pushed to confront his/her negative affect and whatever might be fueling it, he/she may make attempts (whether consciously or unconsciously) to avoid the discomfort of having to do so. When viewed in this light, the multiple co-occurrences of the unproductive processing code with the protection/avoidance code noted in our findings fits with clinical sense.

The term “experiential avoidance” has been conceptualized as an unhealthy process by which “normal” negative feelings, thoughts, and somatic sensations are transformed into disorder (Kashdan & Breen, 2007). Kashdan and Breen liken experiential avoidance to cognitive deconstruction, or a narrowing of attention to

immediate environmental stimuli at the expense of meaningful thoughts about the self. This process, they argue, causes a reduction in meaningful and integrated thinking, while at the same time serving an apparent desire to avoid, or escape, greater self-insight and negative affective states. Furthermore, Kashdan and Breen submit that “cognitive deconstruction is characterized by concrete and rigid thinking, the absence of long-term goals and a decreased sense of meaning” (p. 525). We see, then, that this relationship between unproductive processing, avoidance and negative hope (in the form of absence of goals) is apparently a very powerful one; one that may severely impede the meaning-making process for clients and people in general.

Finally, in reference to the historical antecedent codes, we found that the positive historical antecedent codes (related to early caregivers and not related to early caregivers) co-occurred most frequently with the positive relationship quality code (33%) (assessed as an aspect of the construct of coping) and the cognitive emotional processing code (67%; 2 occasions) of the time. Likewise, the negative historical antecedent codes (related to early caregivers and not related to early caregivers) co-occurred the most with the cognitive emotional processing code (58%; 11 occasions), followed closely by the negative relationship quality code (32%) (also assessed as a part of coping). These findings, once more, make conceptual sense and are in line with much of the literature discussed previously.

The two main points highlighted from these findings are that meaning-making (cognitive-emotional processing) depends largely on the influences of social connectedness and past events, or experiences. The fact that there was a greater overall number of negative historical antecedents that co-occurred with cognitive-emotional

processing (11 separate occasions) compared to positive ones (two separate occasions), also reinforces the notion that clients in the initial stages of therapy tended to more frequently engage in re-evaluation of their present system of beliefs and values when they were recounting certain negative events/experiences from their past (Park & Folkman, 1997), than when they considered positive ones. Although meaning-making frequently occurred when clients reflected on positive past events (67%), client statements were not often coded as positive historical antecedents. This disruption in one's meaning system can be situational, involving some negative social interaction with a family member, friend, partner or peer, or be more global in nature, such as experiencing a traumatic event which is subsequently unable to be understood or accepted by a person based on his/her present beliefs, values, and/or assumptions about the world (Park & Folkman).

#### Methodological Limitations

One methodological limitation in this study had to do with the fact that the data accessed were archival. Thus, the researcher was unable to conduct any "member checks" with the participants, in which the researcher goes back to the participants and presents his observations and findings to see if they fit with what the participants experienced at the time the session took place, or when viewing/hearing it in hindsight (Kazdin, 2003).

Additionally, the data used in this study only included material from the initial stages of therapy sessions (Sessions 1-5). Initial therapy sessions may be a time when clients are beginning to consider new and different ways of perceiving or making-meaning of experiences in their lives (Gendlin, 1982). Consequently, the meaning clients were observed to be making in this study may have been something more akin to unconsciously repeating old meaning structures, or narratives. These narratives may have

helped the client survive in the past, but not necessarily thrive. Rather than keeping these outdated narratives in place, Gendlin (1982) encourages the development of nascent forms of meaning created with the assistance of the therapist by focusing in on the client's "felt sense" of his/her being and helping him/her articulate what is there. Thus, one should be cautious in attempting to generalize this study's results to client material from the middle and end stages of therapy.

It should also be noted that this study involved trainee therapists who were not trained to engage in meaning-making with clients. This is important to consider because beginning therapists may not be as skilled as more seasoned therapists in helping to facilitate new client meaning/narratives, or creating the space in which to do so. Consequently, these findings should only be compared with other studies involving beginning therapists.

Another limitation has to do with the subjective nature of this type of research and the researcher bias, which is present in any study (Mertens, 2005). More specifically, the researcher bias in this case might have affected how the data were categorized into domains and categories, and what patterns/themes emerged from them. Bias was addressed via note taking regarding the researcher's beliefs and rationale for decision making and was then discussed amongst coders during weekly coder meetings. Detailed recordings of the steps taken by the coders throughout the study also helped make the study more replicable and the data more trustworthy. This was done to ensure sufficient credibility, dependability and confirmability in the study (Kazdin, 2003). Using multiple measures of meaning-making as well as related constructs, such as was done in a study about factors related to parents thriving after the trauma of their children being murdered



(Parappully, Rosenbaum, Van Den Daele, & Nzewi, 2002), could also have increased the reliability and validity of the data collected, and also enhanced the richness of it.

The small sample size and population from which the sample was drawn further limited the generalizability of the results from a quantitative standpoint; however, this being a qualitative study, the transferability of the findings should be sufficient for the particular population studied considering the detailed account of the data collection and analysis process (Creswell, 1998). One aspect of the population that was not examined was age. The participants used in this study ranged in age from 21-36, which should be kept in mind when attempting to transfer these results to others, especially considering some of the research which suggests that people have different priorities and perceptions of life at different ages/stages of life (Carlsen, 1991; Erikson, 1968). For example, in a study with very old individuals (aged 76-101 years) suffering from late onset dementia and psychosis, Feil (1989) found that it was more beneficial to these individual's lives to simply accept and validate their feelings and unmet human needs, rather than confront them with present reality through reality testing. Helping these individuals nurture and protect their longstanding belief systems, although possibly outdated and somewhat ineffective, was found to be beneficial due to their familiarity and comfort afforded them (Feil).

#### Potential Contributions of the Present Study and Future Directions

Meaning has already been shown to play an important role in the development and maintenance of healthy psychological functioning, while its absence has been tied to distress and disorder. However, despite the quantitative data about its importance, we know little about how the meaning-making process of people in psychotherapy works. It

is the researcher's hope that this study sheds some much needed light on how people create meaning in the therapeutic context.

Based on our literature review and findings, it appears that the process of meaning-making is a complex, multifaceted one, which is not linear nor ever fully complete. It is more similar to a circular and ongoing feedback loop process of re-examination and updating, which occurs throughout life based on events and our experiences and interactions with others (both positive and negative), including psychotherapists.

We also found that that meaning-making (cognitive-emotional processing) and meaninglessness (unproductive processing) are probably best understood as two points on the same continuum, with degrees of uncertainty and rumination figuring strongly as to where clients presently fall. There is some evidence from the literature which suggests that understanding which type of uncertainty an individual is presently experiencing (situational vs. existential) can help direct the appropriate therapist intervention and focus of attention (Penrod, 2007). Further qualitative research into understanding rumination and the factors which contribute to its presence/manifestation within clients is needed in order to better understand how best to reduce its hold over them; thereby allowing the meaning-making process to play itself out.

One approach we suggest exploring more in-depth is Eugene Gendlin's (1982) concept of focusing. In focusing, the therapist assists the client in becoming more in touch with his/her felt sense of being. Gendlin describes one's felt sense as that which is usually hidden and unable to be articulated/known without first creating a space safe enough to permit the emergence and understanding of the body's core experiences of life.

In other words, it is each person's real reactions to worldly experiences, rather than what each of us tells ourselves things mean based on our background, culture or embedded worldview.

In order to explore the effectiveness of this technique on meaning-making and therapy in general, we suggest enlisting the support of seasoned therapists trained in Gendlin's art of focusing. The study should apply focusing with clients who have struggled with various forms of mental illness throughout their lives, but have been unable to find relief in other forms of therapy thus far. Similar to the present study, we suggest using a mixed-methods approach, in which pre and post measures (such as the Purpose in Life subscale of Ryff's (1989) measure of psychological well-being) would be used to compare each client's level and quality of meaning-making across the course of therapy, as well as a qualitative content analysis of client experiences throughout therapy (Kazdin, 2003). Furthermore, we recommend increasing the sample size to at least 10 participants and increased diversification of the sample to include a wider age distribution (including adolescents, young adults, middle aged adults and the elderly) and a more varied combination of ethnicities, religions, socio-economic statuses, and locations not limited to Southern California.

Another factor supported by our research is that meaning-making derives much of its power from and/or is driven by past and present social interactions with others, primarily those closest to us (family, friends, partners and peers), and within the therapy context. This finding indicates a strong need to include a social component to any measurement attempting to assess clients' level of meaningfulness in life, such as the extent, degree and frequency of social support and positive social interactions they have

on a daily or weekly basis, regardless of presenting problem. The role of culture and how it influences the meaning-making process should, therefore, be examined more closely.

More specifically, some questions that could be examined include: How does environment/culture provide the structure and guiding forces necessary for meaning creation in the individuals immersed in it?; and When do these forces become more detrimental to life (e.g., committing suicide based on certain religious/other delusional belief systems) rather than life enhancing? This could be accomplished by performing an in-depth, longitudinal study in which a diverse sample of people from various religious and cultural groups around the world, both large and small, their families, and their peers are assessed using clinical interviews, self-report measures and writing samples at 6 - month intervals to assess how often they interact and spend time with one another, and how each of them creates meaning/purpose in their lives. By using a mixed-methods design, one could examine the strength environmental factors apparently play in determining an individual's meaning-making system.

These recommendations are in line with a positive psychology framework, in that attempting to measure the construct of meaning-making should include people at both ends of the meaning-making continuum and spectrum (e.g., people who have suffered great tragedies but, nonetheless, have created very meaningful lives (Parappully et al., 2002) and those with more "normal" lives who do not have much meaning/purpose in their lives). When doing so, we strongly suggest that any positive psychologists considering studying meaning-making, or any other vague construct, look to the works and methods of the humanistic/existential researchers who predated positive psychology. Elkins (n.d.) notes that for as much as positive psychology wants to sow its empirical

roots and receive the due respect and recognition the humanistic movement only briefly received and then wrongly lost, traditional quantitative methods are simply inadequate when it comes to capturing complex psychological phenomena such as meaning-making, spirituality and cultural context.

Future research could also critically examine theoretical aspects of meaning-making as applied to the therapy context. More specifically, we suggest testing whether Park and Folkman's (1997) situational and global meaning subtypes fit with Wong's (1998) meaning component parts in this population: (a) does global meaning consist of valued goals, perceiving a rough degree of fairness in the world, having a relationship with a higher power and accepting one's limitations? and (b) does situational meaning consist of: engaging in intimate emotional relationships with others, being sociable and well liked, experiencing positive emotions and engaging in self-transcendent activities?

In addition, researchers could also examine the work of therapists as they endeavor to assist clients in nurturing these various components of a meaningful life. For example, Mascaro and Rosen (1997) advise that, "An authentic sense of meaning in life cannot be imposed, forced, or hammered out of iron but must emerge from relating openly to others, the world and oneself" (p.1006). Because we feel this quotation captures the true essence of how a meaningful life is created, researchers should continue examining how Roger's necessary and sufficient conditions for therapeutic change (empathic understanding, unconditional positive regard, congruence) create the space where clients can practice relating openly to others, the world and one's self in the context of a strong, therapeutic relationship (Rogers, 1961). Research already indicates that the most important factors in therapy outcome effectiveness lay more in the factors

common to all therapy systems (e.g., the therapeutic alliance; the quality of the therapeutic relationship; therapist effects; client expectations) rather than specialized techniques utilized by different orientations (Hubble et al., 1999; Wampold, 2001). Qualitative data could help us further understand how best to create the conditions and space necessary for clients to successfully engage in and complete the meaning-making process in such a way as to be life enhancing, rather than simply life sustaining.

In addition, given the easily perceived power differential within the therapy context (doctor/expert vs. patient/client), more qualitative research needs to be conducted on the second-by-second micro-exchanges going on between therapist and client verbal and non-verbal behaviors to further understand the exchange that takes place as clients attempt to reach some meaningful understanding, or resolution to whatever is presently distressing them. The research surrounding which therapist approach within therapy is most effective appears inconclusive and depends on a number of factors (Hubble et al., 1999). In accord with Roger's (1961) way of creating a relationship of equals within the therapy setting, characterized by empathy, respect and congruence, rather than one of doctor/expert treating patient/client, our findings indicated that an open, non-directive stance by therapists (i.e., asking more open-ended questions, providing empathic reflections/tracking statements) was associated with more cognitive-emotional processing statements made by participants than was a more direct approach (i.e., asking direct questions; making interpretations; giving advice/opinions). Furthermore, our review of the literature and our findings that clients' avoidant statements/behaviors co-occurred frequently with cognitive-emotional processing statements, suggest that some client

resistance indicates he/she is making-meaning of whatever is bringing him/her into therapy.

Researchers, therefore, should continue exploring the impact of therapist verbal and non-verbal behaviors as well as therapist personality and dispositional characteristics on clients' abilities to make meaning in psychotherapy. Verbal and nonverbal behaviors (such as body posture, eye movements, hand gestures, voice fluctuations, breathing rate) and statements related to meaning-making could be examined by working with a small (10-15 participants) diverse sample, using second-by-second micro-exchanges captured with video equipment and analyzed using either a grounded theory or content analytic design. Both researchers and participants alike should be involved in the discussion and analysis of the data, soon after it occurs in session. This ability to include member checks with the participants and confirm what the researchers are finding is considered a vital component (Kazdin, 2003) missing from the present study. Furthermore, examining how client personality, disposition and presenting problems interact with therapists' behaviors, personality and treatment approaches (which was not done in the present study) is also indicated. These variables could be assessed by having both therapists and participants complete personality measures (e.g., MMPI-2, PAI) and other self report measures regarding presenting problems, and perceptions of treatment, the therapist and the client. All this information could then be used in the analysis of the micro-exchanges between therapist and client. In this way, some light might be shed on how therapist and client personality/disposition factors impact meaning-making, the therapeutic exchange and other important factors in the therapy process.

Finally, our study supports previous findings of a strong relationship between meaning and hope, as well as meaninglessness and hopelessness. Leading hope researchers such as Snyder consider hope to be a vital component of a meaningful life, in that meaning helps inform goals in people's lives, which are then actively pursued via the components of hope (agency and pathways). Similarly, we found meaning-making to be closely related to positive hope and a lack of meaning-making (unproductive processing) associated with negative hope.

However, we suggest that creating meaning and a meaningful life is more complex and deeper than simply identifying and achieving goals. We prefer to use the metaphor that it is the journey, or continuous engagement with life and others, not the destination, or specific goal attainment, which most impacts meaning in one's life. Although goal directedness and achievement, by means of hope's agency and pathways is an important component of meaning, if those goals are not congruent with one's true self (Rogers, 1961), then pursuing and achieving them will likely not provide the peace of mind and sense of meaning and purpose in life which humans inherently crave and seek (Frankl, 1967).

Accordingly, more research into the exact nature of the relationship between meaning and hope is necessary in order to better understand how each construct impacts the other. Doing so will help therapists work with clients to more effectively restore aspects of meaning and hope in clients' lives; helping them re-connect with their true selves, getting them back on their true, unique path, and providing the agency and pathways to remain on their life path. We envision research into the relationship between hope and meaning-making occurring within a qualitative frame in order to best capture



all the nuances that exist. In line with the positive psychology perspective advocating for more balance in our research and practice, we recommend examining personal narrative accounts of clients' lives, or specific situations/experiences, at either end of the spectrum (those who are most hopeful and have very meaningful lives as well as their opposites) and in more complex, circular processes. In addition, the cultural context (beliefs/values) within which people's lives are embedded, needs to be taken into account when examining any relationship between meaning and hope. For now, though, we agree with Feldman and Snyder's (2005) suggestion that for those who view their life as meaningless, training in hope (i.e., agency and pathways) may prove helpful as an adjunct for traditional existential psychotherapies.

In conclusion, it is hoped that therapists can use some of the information shared in this dissertation to integrate discussions of meaning in their work with clients and help ignite the meaning-making process more effectively in them. According to Mascaro and Rosen (2005),

Viktor Frankl proposed long ago that in order to overcome psychologically painful situations, one must shift from a 'what do I want from life' attitude, towards a 'what does life want from me?' attitude, to transcend desires for pleasure or power and, instead, fulfill the uniquely human will to meaning—to find the *why* in situations that are ostensibly absurd. (p. 987)

Doing so, we submit, will not only help clients' lives flourish, but also will help them become more resilient to and hopeful during the natural ups and downs of life, along with the uncertainty that it inevitably brings. It is the management of this uncertainty, not the eradication of it, which should be the goal for all of us. For just as uncertainty amplifies the negative experiences we have, so it does the positive ones as well (Bar-Anan, Wilson, & Gilbert, 2006). In fact, one might go so far as to say that it is uncertainty which

actually makes life so exciting and worth living. We submit that taking Frankl's approach to life provides one with a special resiliency, purpose and sense of hope, while at the same time acts as a buffer against existential angst and the destructive forces of depression and hopelessness.

## References

- Allport, G. W. (1958). *Becoming: Basic considerations for a psychology of personality*. Oxford, England: Verlag.
- Allport, G.W. (1961). *Patterns and growth in personality*. New York: Holt, Rinehart & Winston.
- Anderson, H. (1997). *Conversation, language, and possibilities: A postmodern approach to therapy*. New York: Basic Books.
- Angus, L., Levitt, H., & Hardtke, K. (1999). The narrative processes coding system: Research applications and implications for psychotherapy practice. *Journal of Clinical Psychology*, 55, 1255-1270.
- Antonovsky, A. (1987). *Unraveling the mystery of health: How people manage stress and stay well*. San Francisco: Jossey-Bass.
- Bar-Anan, Y., Wilson, T. D., & Gilbert, D. T. (2009). The feeling of uncertainty intensifies affective reactions. *Emotion*, 9(1), 123-127.
- Battista, J., & Almond, R. (1973). The development of meaning in life. *Psychiatry*, 36, 409-427.
- Baumeister, R. F. (1991). *Meanings of life*. New York: Guilford.
- Baumeister, R. F., & Vohs, K. D. (2005). The pursuit of meaningfulness in life. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 608-618). London: Oxford University Press.
- Baumeister, R. F., & Wilson, B. (1996). Life stories and the four needs for meaning. *Psychological Inquiry*, 7(4), 322-377.
- Benard, B. (1991). *Fostering resiliency in kids: Protective factors in the family, school, and community*. San Francisco: Western Regional Center for Drug Free Schools and Communities, Far West Laboratory.
- Bischoff, M. M., & Tracey, T. J. G. (1995). Client resistance as predicted by therapist behavior: A study of sequential dependence. *Journal of Counseling Psychology*, 42(4), 487-495.
- Bohart, A. C., & Greening, T. (2001). Humanistic psychology and positive psychology. *American Psychologist*, 56, 81-82.

- Bonebright, C. A., Clay, D. L., & Ankenmann, R. D. (2000). The relationship of workaholism with work—life conflict, life satisfaction, and purpose in life. *Journal of Counseling Psychology, 47*, 469-477.
- Boyd, G. E. (2003). Pastoral conversation: Relational listening and open-ended questions. *Pastoral Psychology, 51*(5), 345-360.
- Burck, C. (2005). Comparing qualitative research methodologies for systemic research: The use of grounded theory, discourse analysis and narrative analysis. *The Association for Family Therapy and Systemic Practice, 27*, 237-262.
- Cacioppo, J. T., Hawkey, L. C., Rickett, E. M., & Masi, C. M. (2005). Sociality, spirituality, and meaning making: Chicago health, aging, and social relations study. *Review of General Psychology, 9*(2), 143-155.
- Carlsen, M. B. (1991). *Creative aging: A meaning-making perspective*. New York: Norton.
- Chamberlain, K., & Zika, S. (1988). Measuring meaning in life: An examination of three scales. *Personality and Individual Differences, 9*, 589-596.
- Clarke, K. M. (1996). Change processes in a creation of meaning event. *Journal of Consulting and Clinical Psychology, 64*, 465-470.
- Cottone, R. R. (2001). A social constructivism model of ethical decision making in counseling. *Journal of Counseling and Development, 79*, 39-45.
- Cottone, R. R. (2007). Paradigms of counseling and psychotherapy, revisited: Is social constructivism a paradigm? *Journal of Mental Health Counseling, 29*(3), 189-203.
- Courtenay, B. C., Merriam, S. B., & Reeves, P. M. (1998). The centrality of meaning-making in transformational learning: How HIV-positive adults make sense of their lives. *Adult Education Quarterly, 48*, 65-84.
- Cowen, E. L. (2000). Now that we all know that primary prevention in mental health is great, what is it? *Journal of Community Psychology, 28*(1), 5-16.
- Creswell, J. W. (1998). *Qualitative inquiry and research designs, choosing among five traditions*. Thousand Oaks, CA: Sage.
- Crumbaugh, J. C., & Maholick, L. T. (1964). An experimental study of existentialism: The psychometric approach to Frankl's concept of noogenic neurosis. *Journal of Clinical Psychology, 20*, 200-207.

- Csikszentmihalyi, M. (2003). Legs or wings? A reply to R. S. Lazarus. *Psychological Inquiry*, 14(2), 113-115.
- Dahlsgaard, K., Peterson, C., & Seligman, M. E. P. (2005). Shared virtue: The convergence of valued human strengths across culture and history. *Review of General Psychology*, 9, 209-213.
- Debats, D. L. (1999). Sources of meaning: An investigation of significant commitments in life. *Journal of Humanistic Psychology*, 39, 30-57.
- Debats, D., Drost, J., & Hansen, P. (1995). Experiences of meaning in life: A combined qualitative and quantitative approach. *British Journal of Psychology*, 86, 359-375.
- Debats, D. L., Van der Lubbe, P. M., & Wezeman, F. R. A. (1993). On the psychometric properties of the Life Regard Index (LRI): A measure of meaningful life. *Personality and Individual Differences*, 14, 337-345.
- Diener, E., & Suh, E. (1997). Measuring quality of life: Economic, social, and subjective indicators. *Social Indicators Research*, 40, 189-216.
- Duckworth, A. L., Steen, T. A., & Seligman, M. E. P. (2005). Positive psychology in clinical practice. *Annual Review of Clinical Psychology*, 1, 629-651.
- Dyck, M. J. (1987). Cognitive therapy and logotherapy: Contrasting views on meaning. *Journal of Cognitive Psychotherapy*, 1(3), 155-169.
- Elkins, D. N. (in press). Why humanistic psychology lost its power and influence in American psychology: Implications for advancing humanistic psychology. *Journal of Humanistic Psychology*.
- Elkins, D. N. (n.d.). Whatever happened to Carl Rogers? An examination of the politics of clinical psychology. Unpublished manuscript, Pepperdine University, Culver City, CA.
- Elliott, I., & Coker, S. (2008). Independent self-construal, self-reflection, and self-rumination: A path model for predicting happiness. *Australian Journal of Psychology*, 60(3), 127-134.
- Emmons, R. (1999). *The psychology of ultimate concerns: Motivation and spirituality in personality*. New York: Guilford.
- Erikson, E. H. (1968). *Identity: Youth and crisis*. New York: W. W. Norton.
- Feil, N. (1989). Validation: An empathic approach to the care of dementia. *Clinical Gerontologist*, 8(3), 89-94.

- Feldman, D. B., & Snyder, C. R. (2005). Hope and the meaningful life: Theoretical and empirical associations between goal-directed thinking and life meaning. *Journal of Social and Clinical Psychology, 24*(3), 401-421.
- Flores, L. Y., & Obasi, E. M. (2003). Positive psychological assessment in an increasingly diverse world. In S. J. Lopez & C.R. Snyder (Eds.), *Positive psychological assessment* (pp. 41-54). Washington, DC: American Psychological Association.
- Folkman, S., & Greer, S. (2000). Promoting psychological well-being in the face of serious illness: when theory, research and practice inform each other. *Psychooncology, 9*, 11-19.
- Folkman, S., & Moskowitz, J. T. (2000). Positive affect and the other side of coping. *American Psychologist, 55*, 647-654.
- Frankl, V. E. (1959). *Man's search for meaning: An introduction to logotherapy*. Boston: Beacon.
- Frankl, V. E. (1963). *Man's search for meaning: An introduction to logotherapy*. New York: Washington Square Press.
- Frankl, V. (1967). *Psychotherapy and existentialism: Selected papers on Logotherapy*. London: Hazell Watson & Viney, LTD.
- Gable, S. L., & Haidt, J. (2005). What (and why) is positive psychology? *Review of General Psychology, Vol. 9*(2), 103-110.
- Gendlin, E. T. (1982). *Focusing*. New York: Bantam.
- Grossman, F. K., Sorsoli, L., & Kia-Keating, M. (2006). A gale force wind: meaning making by male survivors of childhood sexual abuse. *American Journal of Orthopsychiatry, 76*(4), 434-443.
- Halstead, M. T. & Hull, M. (2001). Struggling with paradoxes: the process of spiritual development in women with cancer. *Oncology Nursing Forum, 28*, 1534-1544.
- Harlow, L. L., Newcomb, M. D., & Bentler, P. M. (1986). Depression, self-derogation, substance abuse, and suicide ideation: Lack of purpose in life as a meditational factor. *Journal of Clinical Psychology, 42*, 5-21.
- Harvey, J. H., Orbuch, T. L., & Weber, A. L. (1990). A social psychological model of account-making in response to severe stress. *Journal of Language and Social Psychology, 9*, 191-207.

- Haverkamp, B. E., & Young, R. A. (2007). Paradigms, purpose, and the role of the literature: Formulating a rationale for qualitative investigations. *Counseling Psychologist, 35*(2), 265-294.
- Hayes, A. M., Beevers, C. G., Feldman, G. C., Laurenceau, J., & Perlman, C. (2005). Avoidance and processing as predictors of symptom change and positive growth in an integrative therapy for depression. *International Journal of Behavioral Medicine, 12*(2), 111-122.
- Hayes, A. M., & Feldman, G. C. (2005). *The change and growth experiences scale (CHANGE): Client variables*. University of Delaware: Unpublished manual.
- Hayes, A. M., Feldman, G. C., & Goldfried, M. R. (2007). The change and growth experiences scale: A measure of insight and emotional processing. In L. G. Castonguay & C. Hill (Eds.), *Insight in psychotherapy*. Washington, DC: American Psychological Association.
- Held, B. S. (2004). The negative side of positive psychology. *Journal of Humanistic Psychology, 44*, 9-46.
- Hill, C. E., Corbett, M. M., Kanitz, B., Rios, P., Lightsey, R., & Gomez, M. (1992). Client behavior in counseling and therapy sessions: Development of a pantheoretical measure. *Journal of Counseling Psychology, 39*, 539-549.
- Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.). (1999). *The heart and soul of change: What works in therapy*. Washington, DC: American Psychological Association.
- Iyengar, S.S., and M.R., Lepper. 2000. When choice is demotivating: can one desire too much of a good thing? *Journal of Personality and Social Psychology, 79*, 995-1006.
- James, W. (1902). *The varieties of religious experience: A study in human nature*. New York: Longman, Green.
- Jones, A. S., & Gelso, C. J. (1988). Differential effects of style of interpretation: Another look. *Journal of Counseling Psychology, 35*, 363-369.
- Kashdan, T. B., & Breen, W. E. (2007). Materialism and diminished well-being: Experiential avoidance as a mediating mechanism. *Journal of Social and Clinical Psychology, 26*(5), 521-539.
- Kazdin, A. E. (Ed.). (2003). *Methodological issues and strategies in clinical research* (2<sup>nd</sup> ed.). Washington, DC: American Psychological Association.

- Kenyon, G. M. (2000). Philosophical foundation of existential meaning. In G. T. Reker & K. Chamberlain (Eds.), *Exploring existential meaning: Optimizing human development across the life span* (pp. 7-22). Thousand Oaks, CA: Sage.
- Keyes, C. L. M., & Lopez, S. J. (2002). Toward a science of mental health: Positive directions in diagnosis and interventions. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 45-59). London: Oxford University Press.
- Klein, M. H., Mathieu-Coughlan, P., & Kiesler, D. J. (1986). The experiencing scales. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook*. (pp.21-71). New York: Guilford.
- Kinnier, R., Metha, A. T., Keim, J. S., & Okey, J. L. (1994). Depression, meaninglessness, and substance abuse in “normal” and hospitalized adolescents. *Journal of Alcohol and Drug Education*, 39(2), 101-111.
- Kirschenbaum, H. (2004). Carl Rogers’s life and work: An assessment on the 100<sup>th</sup> anniversary of his birth. *Journal of Counseling and Development*, 82, 116-124.
- Kish, G., & Moody, D. (1989). Psychopathology and life purpose. *International Journal of Logotherapy*, 12(1), 40-45.
- Kishon-Barash, R., Midlarsky, E., & Johnson, D. R. (1999). Altruism and the Vietnam War veteran: The relationship of helping to symptomatology. *Journal of Traumatic Stress*, 12, 655-662.
- Klinger, E. (1977). *Meaning and void*. Minneapolis: University of Minnesota Press.
- Kuehlwein, K. T. (1996). Interweaving themes and threads of meaning-making. In H. Rosen & K. Kuehlwein (Eds.), *Constructing realities: Meaning-making perspectives for psychotherapists* (pp. 491-512). San Francisco: Jossey-Bass.
- Landmark, B. T., Strandmark, M. & Wahl, A. K. (2001). Living with newly diagnosed breast cancer – the meaning of existential issues. A qualitative study of 10 women with newly diagnosed breast cancer, based on grounded theory. *Cancer Nursing*, 24, 220-226.
- Lazarus, R. S. (2003). Does the positive psychology movement have legs? *Psychological Inquiry*, 14(2), 93-109.
- Lewis, S. E. (1995). A search for meaning: Making sense of depression. *Journal of Mental Health*, 4(4), 369-382.



- Lopez, S. J., Prosser, E. C., Edwards, L. M., Magyar-Moe, J. L., Neufield, J. E., & Rasmussen, H. N. (2002). Putting positive psychology in a multicultural context. In C. R. Snyder & J. Shane (Eds.), *Handbook of positive psychology* (pp. 700-714). Oxford, UK: Oxford University Press.
- Lopez, S. J., & Snyder, C. R. (2003). The future of positive psychological assessment: Making a difference. In S. J. Lopez & C. R. Snyder (Eds.), *Positive psychological assessment* (pp. 461-468). Washington, DC: American Psychological Association.
- Lyubomirsky, S. (2001). Why are some people happier than others? The role of cognitive and motivational processes in well-being. *American Psychologist*, *56*, 239-249.
- Lyubomirsky, S., & Ross, L. (1999). Changes in attractiveness of elected, rejected, and precluded alternatives: A comparison of happy and unhappy individuals. *Journal of Personality and Social Psychology*, *76*, 988-1007.
- Maddux, J. E. (2002). Stopping the "madness": Positive psychology and the deconstruction of the illness ideology and the DSM. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 13-25). New York: Oxford University Press.
- Mascaro, N., & Rosen, D. H. (2005). Existential meaning's role in the enhancement of hope and prevention of depressive symptoms. *Journal of Personality*, *73*(4), 986-1013.
- Maslow, A. H. (1968). *Toward a psychology of being*. New York: Van Nostrand.
- McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York: Morrow.
- Mertens, D. M. (2005). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Michael, S. T., & Snyder, C. R. (2005). Getting unstuck: The roles of hope, finding meaning, and rumination in the adjustment to bereavement among college students. *Death Studies*, *29*, 435-458.
- Morrow, J., & Nolen-Hoeksema, S. (1990). Effects of responses to depression on the remediation of depressive affect. *Journal of Personality and Social Psychology*, *58*, 519-527.
- Myers, D. (2000). The funds, friends, and faith of happy people. *American Psychologist*, *55*, 56-67.

- Nelson, J. P. (1996). Struggling to gain meaning: living with the uncertainty of breast cancer. *Advances in Nursing Science, 18*, 59-76.
- Nolen-Hoeksema, S., McBride, A., & Larson, J. (1997). Rumination and psychological distress among bereaved partners. *Journal of Personality and Social Psychology, 72*, 855-862.
- Nolen-Hoeksema, S., & Morrow, J. (1993). Effects of rumination and distraction on naturally occurring depressed mood. *Cognition and Emotion, 7*, 561-570.
- Norem, J. K., & Chang, E. C. (2002). The positive psychology of negative thinking. *Journal of Clinical Psychology, 58*, 993-1001.
- O'Connor, A. P., Wicker, C. A., & Germino, B. B. (1990). Understanding the cancer patient's search for meaning. *Cancer Nursing, 13*, 167-175.
- O'Cleirigh, C., Ironson, G., Antoni, M., Fletcher, M. A., McGuffey, L., Balbin, E., Schneiderman, N., & Solomon, G. (2003). Emotional expression and depth processing of trauma and their relation to long-term survival in patient with HIV/AIDS. *Journal of Psychosomatic Research, 54*, 225-235.
- Ohman, M., Soderberg, S., & Lundman, B. (2003). Hovering between suffering and enduring: the meaning of living with serious chronic illness. *Qualitative Health Research, 13*, 528-542.
- Parappully, J., Rosenbaum, R., Van Den Daele, L., & Nzewi, E. (2002). Thriving after trauma: The experience of parents of murdered children. *Journal of Humanistic Psychology, 42*(1), 33-70.
- Park, C. L., & Folkman, S. (1997). Meaning in the context of stress and coping. *Review of General Psychology, 1*(2), 115-144.
- Park, N., Peterson, C., & Seligman, M. E. P. (2006). Character strengths in fifty-four nations and the fifty US states. *Journal of Positive Psychology, 1*(3), 118-129.
- Pennebaker, J. W., Colder, M., & Sharp, L. K. (1990). Accelerating the coping process. *Journal of Personality and Social Psychology, 58*, 528-537.
- Penrod, J. (2007). Living with uncertainty: Concept advancement. *Journal of Advanced Nursing, 57*(6), 658-667.
- Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A handbook and classification*. Washington, DC: American Psychological Association.

- Rand, K. L., & Snyder, C. R. (2003). A reply to Dr. Lazarus, the evocator emeritus. *Psychological Inquiry, 14*(2), 148-153.
- Ray, R. D., Wilhelm, F. erH., & Gross, J. J. (2008). All in the mind's eye? Anger, rumination and reappraisal. *Journal of Personality and Social Psychology, 94*(1), 133-145.
- Reker, G. T., & Wong, P. T. P. (1988). Aging as an individual process: Toward a theory of personal meaning. In J. E. Birren & V. L. Bengston (Eds.), *Emergent theories of aging* (pp. 214-246). New York: Springer.
- Robbins, B. D. (2008). What is the good life? Positive psychology and the renaissance of humanistic psychology. *The Humanistic Psychologist, 36*, 96-112.
- Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton Mifflin.
- Rosen, H. (1996). Foundations for constructivist and social constructivist psychotherapies. In H. Rosen & K. Kuehlwein (Eds.), *Constructing realities: Meaning-making perspectives for psychotherapists* (pp. 3-43). San Francisco: Jossey-Bass.
- Rude, S. S., Maestas, L., & Neff, K. (2007). Paying attention to distress: What's wrong with rumination? *Cognition and Emotion, 21*(4), 843-864.
- Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57*, 1069-1081.
- Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology, 69*, 719-727.
- Ryff, C. D., & Singer, B. (1998). The contours of positive human health. *Psychological Inquiry, 9*, 1-28.
- Schilling, J. (2006). On the pragmatics of qualitative assessment: Designing the process for content analysis. *European Journal of Psychological Assessment, 22*(1), 28-37.
- Schwartz, B. (2004). *The paradox of choice: Why more is less*. New York: HarperCollins.
- Schwartz, B., Ward, A., Monterosso, J., Lyubomirsky, S., White, K., & Lehman, D. R. (2002). Maximizing versus satisficing: happiness is a matter of choice. *Journal of Personality and Social Psychology, 83*, 1178-1197.
- Seligman, M. E. P. (2002). *Authentic happiness*. New York: Free Press.

- Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive Psychology: An introduction. *American Psychologist*, 55, 5-14.
- Sheldon, K., Frederickson, B., Rathunde, K., Csikszentmihalyi, & Haidt, J. (2002). Retrieved May 8, 2007, from University of Pennsylvania, Positive Psychology Center Web site: <http://www.ppc.sas.upenn.edu/akumalmanifesto.htm>
- Simonton, D. K., & Baumeister, R. F. (2005). Positive psychology at the summit. *Review of General Psychology*, 9(2), 99-102.
- Skaggs, B. G., & Barron, C. R. (2006). Searching for meaning in negative events: concept analysis. *Journal of Advanced Nursing*, 53(5), 559-570.
- Smith, D. J., & Washburn, D. A. (2005). Uncertainty monitoring and metacognition by animals. *Current Directions in Psychological Science*, 14, 19-24.
- Snyder, C. R. (2002). Hope theory: Rainbows in the mind. *Psychological Inquiry*, 13(4), 249-275.
- Snyder, C. R., Lopez, S. J., Edwards, L. M., Pedrotti, J. T., Prosser, E. C., Walton, S. L., et al. (2003). Measuring and labeling the positive and negative. In S. J. Lopez & C. R. Snyder (Eds.), *Positive psychological assessment* (pp. 21-39). Washington, DC: American Psychological Association.
- Strauss, A., & Corbin, J. M. (1990) *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park: Sage.
- Steger, M. F., Frazier, P., Kaler, M., & Oishi, S. (2006). The Meaning in life questionnaire: Assessing the presence of and search for meaning in life. *Journal of Counseling Psychology*, 53(1), 80-93.
- Stiles, W. B., Elliot, R., Llewelyn, S. P., Firth-Cozens, J. A., Margison, F. R., Shapiro, D. A., & Hardy, G. (1990). Assimilation of problematic experiences by clients in psychotherapy. *Psychotherapy: Theory, research, practice, & training*, 27, 411-420.
- Strong, T. (2003). Getting curious about meaning-making in counseling. *British Journal of Guidance & Counseling*, 31(3), 259-273.
- Taylor, S. E. (1983). Adjustment to threatening events: a theory of cognitive adaptation. *American Psychologist*, 38, 1161-1173.
- Taylor, S. E., Kemeny, M. E., Reed, G. M., Bower, J. E., & Gruenwald, T. L. (2000). Psychological resources, positive illusions, and health. *American Psychologist*, 55, 99-109.

- Tracey, T. J. (1986). Interactional correlates of premature termination. *Journal of Consulting and Clinical Psychology, 54*, 784-788.
- Tracey, T. J., & Ray, P. B. (1984). The stages of successful time-limited counseling: An interactional examination. *Journal of Counseling Psychology, 31*, 13-27.
- Thompson, S. C. (1985). Finding positive meaning in a stressful event and coping. *Basic and Applied Psychology, 6*, 279-295.
- Thomsen, D. K. (2006). The association between rumination and negative affect: A review. *Cognition and Emotion, 20*(8), 1216-1235.
- Uebersax, J. (2007). Methods for likert-type or interval-level data. In *Statistical methods for rater agreement*. Retrieved December 7, 2008, from <http://ourworld.compuserve.com/homepages/jsuebersax/agree.htm>
- Viney, L. L. (1983). The assessment of psychological states through content analysis of verbal communications. *Psychological Bulletin, 94*(3), 542-563.
- Walrath, C. M., Mandell, D. S., Holden, W., & Santiago, R. L. (2004). Assessing the strengths of children referred for community-based mental health services. *Mental Health Services Research, 6*(1), 1-8.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Waters, D. (1994). Prisoners of our metaphors: Do dialogic therapies make other methods obsolete? *The Family Therapy Networker, 12*, 73-75.
- White, M. & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: WW Norton.
- Wilson, T. D., & Gilbert, D. T. (2008). Explaining away: A model of affective adaption. *Perspectives of Psychological Science, 3*, 370-386.
- Wong, P. T. (1998). Implicit theories of meaningful life and the development of the personal meaning profile. In P. T. P. Wong & P. S. Fry (Eds.), *The human quest for meaning: A handbook of psychological research and clinical applications* (pp. 111-140). Mahwah, NJ: Lawrence Erlbaum.
- Yalom, I. (1980). *Existential psychotherapy*. New York: Basic Books.
- Zika, S., & Chamberlain, K. (1987). Relation of hassles and personality to subjective well-being. *Journal of Personality and Social Psychology, 53*, 155-162.

Zika, S., & Chamberlain, K. (1992). On the relation between meaning in life and psychological well-being. *British Journal of Psychology*, 83, 133-145.

## APPENDIX A

## Client Consent Form

**Pepperdine University**  
**Counseling and Educational Clinics**  
**Consent for Services**

INITIALS

Welcome to Pepperdine University's Counseling and Educational clinics. Please read this document carefully because it will help you make an informed decision about whether to seek services here. This form explains the kinds of services our clinic provides and the terms and conditions under which services are offered. Because our clinic complies with the Health Insurance Portability and Accountability Act (HIPAA), be sure to review the Privacy Rights pamphlet that was also given to you today. It is important that you understand the information presented in this form. If you have any questions, our staff will be happy to discuss them with you.

Who We Are: Because the clinic is a teaching facility, graduate students in either the Clinical Psychology Doctorate Program or the Masters in Marriage and Family Therapy Program provide the majority of services. Our graduate student therapists are placed in the clinic for a time-limited training position, which typically lasts 8-12 months. In all cases, all therapists are supervised by a licensed clinical psychologist or a team that includes a licensed mental health professional. The clinic is housed in Pepperdine University and follows the University calendar. As a general rule, the clinic will be closed when the University is not in session. No psychological services will be provided at those times.

- I understand and agree that my services will be provided by an unlicensed graduate student therapist who will be working under the direct supervision of a licensed mental health professional.
- I understand and agree that, as required by law, my therapist may disclose any medical, psychological or personal information concerning me to his/her supervisor(s).
- I confirm that I have been provided with information on how to contact my therapist's supervisor(s) should I wish to discuss any aspects of my treatment.

I understand and agree with the above three statements.

Services: Based on the information you provided in your initial telephone interview, you have been referred to the professional service in our clinic appropriate to your concern. The clinic provides the following professional psychological services:



*Psychotherapy:* The first few sessions of therapy involve an evaluation of your needs. At the end of the evaluation phase, a determination will be made regarding whether our services appropriately match your mental health needs. A determination will also be made regarding whether to continue with services at our clinic, or to provide you with a referral to another treatment facility more appropriate to your needs. As part of your services, you will be asked to complete questionnaires during your intake session, at periodic intervals (e.g., every fifth session), and after you have completed treatment. Psychotherapy has both benefits and risks. Risks sometimes include being asked to discuss unpleasant aspects of your life and experiencing uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Sometimes decisions are made in therapy that are positive for one family member and can be viewed negatively by another family member. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no guarantees of what you will experience. In order for therapy to be effective, a commitment to regular attendance is necessary. Frequent cancellations or missed therapy appointments may result in termination of services or a referral to an alternative treatment setting. Unless otherwise arranged, therapy sessions are scheduled once a week for 50 minutes. Educational Therapy is also offered in some of our clinics. This is an intervention that focuses on learning difficulties by addressing how circumstances in a person's life contribute to these difficulties. Educational therapy combines tutoring as well as attention to socio-emotional issues that affect learning.

*Psychological Assessment:* The clinic provides psychological and psychoeducational assessments. These assessments may be initiated by you, your therapist or a third party. Assessment sessions are longer than therapy sessions and can take several hours to complete. The number of sessions required for conducting the assessment will be determined based on the nature and number of tests administered. You have the right to request a copy of your assessment report and test data. You also have the right to receive feedback regarding your assessment results. However, there are some situations in which we may not be able to release test results, including test data, to you: a) When such a disclosure may cause substantial harm or misuse of the test results and test data, and/or b) When you were notified and agreed in advance and in writing that the assessment was ordered and/or paid for by a third party and that we would release your results only to that third party. The benefits of psychological assessment include a clearer understanding of your cognitive and emotional functioning. Although the risks of participating in a psychological assessment are generally no greater than the risks of counseling, test results may reveal information that may be painful and/or difficult to accept. If that is the case, we recommend that you review with the examiner options for addressing your concerns.

*Consent to Video/audiotaping and Observations:* It is standard procedure at our clinic for sessions to be audiotaped and videotaped for training/teaching and/or



research purposes. **It should be noted that videotaping for teaching/training purposes is a prerequisite for receiving services at our clinic.** In addition, sessions may be observed by other therapists and/or supervisors at the clinic through the use of a one-way mirror or direct in-session observation.

- For Teaching/Training purposes, check all that apply:  
I understand and agree to

\_\_\_\_\_ Video/audiotaping  
\_\_\_\_\_ Direct Observation

**Psychological Research:** As a university based clinic, we engage in research activities in order to determine the effectiveness of our services, including client satisfaction, as well as to better understand assessment and therapy practices. Participation in research is totally voluntary and means that the forms you complete as a part of your treatment will be placed in a secure research database. Clinic staff will remove any of your identifying information (e.g., name, address, date of birth) from the written materials before they are placed in the database. You may also consent to have your taped sessions included in the research database, and if so these tapes will be used and stored in a confidential manner. Only those professors and graduate students who have received approval from the Clinic Research Committee, and who have signed confidentiality agreements, will be granted access to the database in order to conduct scholarly research. If any information from the database is involved in a published study, results will be discussed in reference to participant groups only, with no personally identifying information released. Your services do not depend on your willingness to have your written and/or taped materials included in our research database. You may also change your mind about participation in the research database at any time. While there is no direct benefit to you to have your materials placed in the database, your participation may provide valuable information to the field of psychology and psychotherapy.

**Please choose from the following options (confirm your choice by initialing in the margin).**

- I understand and agree that information from my services will be included in the Research Database (check all that apply).

\_\_\_\_\_ Written Data  
\_\_\_\_\_ Videotaped Data  
\_\_\_\_\_ Audiotaped Data

OR

- I do not wish to have my information included in the Research Database.

- 
- I understand and agree that I may be contacted in the future about the opportunity to participate in other specific research programs.

OR

- I do not wish to be contacted in the future about the opportunity to participate in other specific research programs.

Fees: The fee for the initial intake is nonrefundable. Payment for services is due at the time the services are rendered. Your ongoing fee will be based on your income (for minors: the income of your parents) or upon your ability to pay. Once an appointment is scheduled, you will be expected to pay for it unless you provide 24-hour notice of cancellation prior to the appointment time. Please notify us of your cancellation via phone. Please do not use E-mail since we cannot guarantee a secure and confidential correspondence. Failure to pay for services may result in the termination of treatment and/or the use of an outside collection agency to collect fees. In most collection situations, the only information released is your name, the nature of services provided and amount due.

*Payment for psychological assessment services:* The intake fee is due at the time of the first appointment. Following this appointment, the full cost of the psychological testing will be determined. Payment in full for the psychological testing is required prior to the completion of the testing. Feedback from the testing as well as a test report will be provided after payment has been made in full. Fees for psychological testing cover: initial interview, test administration, scoring and interpretation, oral feedback of test results, and a written test report. Any additional services requested will be billed separately.

After Hours and Emergency Contact: Should you need to reach your therapist during or after business hours you may leave a message on the clinic's voice-mail. The therapist will most likely return your call by the next day. Should you need to contact your therapist for an urgent matter, you may use the clinic's pager number, provided to you, to get in touch with the on-call therapist. Please be aware that the clinic is not equipped to provide emergency psychiatric services. Should you need such services, during and/or after business hours, you will be referred to more comprehensive care centers in the community.

Confidentiality & Records: All communications between you and your therapist are strictly confidential and may not be disclosed to anyone outside the clinic staff without your written authorization. However, there are some situations in which disclosure is permitted or required by law, without your consent or authorization:

- Your therapist may consult with other mental health professionals regarding your case. The consultants are usually affiliated with Pepperdine University. Your therapist may also discuss your case in other teaching activities at Pepperdine, such as class discussions, presentations and exams. Every effort is made to avoid revealing your identity during such teaching activities.

- If the situation involves a serious threat of physical violence against an identifiable victim, your therapist must take protective action, including notifying the potential victim and contacting the police.
- If your therapist suspects the situation presents a substantial risk of physical harm to yourself, others, or property he/she may be obligated to seek hospitalization for you or to contact family members or others who can help.
- If your therapist suspects that a child under the age of 18, an elder, or a dependent adult has been a victim of abuse or neglect, the law requires that he/she file a report with the appropriate protective and/or law enforcement agency.
- If you are involved in a court proceeding and a request is made for information about the services provided to you, the clinic cannot provide any information, including release of your clinical records, without your written authorization, a court order, or a subpoena.
- If you file a complaint or lawsuit against your therapist and/or the clinic, disclosure of relevant information may be necessary as part of a defense strategy.
- If a government agency is requesting the information pursuant to their legal authority (e.g., for health oversight activities), the clinic may be required to provide it for them.
- If the clinic has formal business associates who have signed a contract in which they promise to maintain the confidentiality of your information except as specifically allowed in the contract or otherwise required by law.

If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action. Disclosure will be limited to what is necessary for each situation.

**Your Records:** The clinic keeps your Protected Health Information in your clinical records. You may examine and/or receive a copy of your records, if you request it in writing, except when: (1) the disclosure would physically or psychologically endanger you and/or others who may or may not be referenced in the records, and/or (2) the disclosure includes confidential information supplied to the clinic by others.

HIPAA provides you with the following rights with regard to your clinical records:

- You can request to amend your records.
- You can request to restrict from your clinical records the information that we can disclose to others.
- You can request an accounting of authorized and unauthorized disclosures we have made of your clinical records.
- You can request that any complaints you make about our policies and procedures be recorded in your records.

- You have the right to a paper copy of this form, the HIPAA notice form, and the clinic's privacy policies and procedures statement.

The clinic staff is happy to discuss your rights with you.

Treatment & Evaluation of Minors:

As an unemancipated minor (under the age of 18) you can consent to services subject to the involvement of your parents or guardians.

- Over the age of 12, you can consent to services if you are mature enough to participate in services and you present a serious danger to yourself and/or others or you are the alleged victim of child physical and/or sexual abuse. In some circumstances, you may consent to alcohol and drug treatment.
- Your parents or guardians may, by law, have access to your records, unless it is determined by the child's therapist that such access would have a detrimental effect on the therapist's professional relationship with the minor or if it jeopardizes the minor's physical and/or psychological well-being.
- Parents or guardians will be provided with general information about treatment progress (e.g., attendance) and they will be notified if there is any concern that the minor is dangerous to himself and/or others. For minors over the age of 12, other communication will require the minor's authorization.
- All disclosures to parents or guardians will be discussed with minors, and efforts will be made to discuss such information in advance.

My signature or, if applicable, my parent(s) or guardian's signature below certifies that I have read, understood, accepted, and received a copy of this document for my records. This contract covers the length of time the below named is a client of the clinic.

	and/or	
Signature of client, 18 or older (Or name of client, if a minor)		Signature of parent or guardian
		Relationship to client
		Signature of parent or guardian
		Relationship to client

\_\_\_\_\_ please check here if client is a minor. The minor's parent or guardian must sign unless the minor can legally consent on his/her own behalf.

\_\_\_\_\_  
Clinic/Counseling Center  
Representative/Witness

\_\_\_\_\_  
Translator

\_\_\_\_\_  
Date of signing

## APPENDIX B

## Therapist Consent Form

**INFORMED CONSENT FOR THERAPIST PARTICIPATION  
IN PEPPERDINE CLINICS RESEARCH DATABASE PROJECT**

1. I, \_\_\_\_\_, agree to participate in the research database project being conducted under the direction of Drs. Eldridge, Ellis, and Hall, in collaboration with the clinic directors. I understand that while the study will be under the supervision of these Pepperdine GSEP faculty members, other personnel who work with them may be designated to assist or act in their behalf. I understand that my participation in this research database is strictly voluntary.
2. One purpose of research at the Pepperdine University GSEP Clinics and Counseling Centers is to examine the effectiveness of new clinic policies and procedures that are being implemented. This is being done through standard internal clinic practices (headed by the clinic directors and the Clinic Advancement and Research Committee) as well as through the construction of a separate research database (headed by Drs. Eldridge, Ellis, and Hall). Another purpose of this research project is to create a secure database from which to conduct research projects by the faculty members and their students on other topics relevant to clinical practice.
3. I have been asked to participate in the research database project because I am a student therapist or intern at a GSEP Clinic or Counseling Center. Because I will be implementing the new clinic policies and procedures with my clients, my input (or participation) will provide valuable data for the research database.

My participation in the research database project can involve two different options at this point. I can choose to participate in any or neither of these options by initialing my consent below each description of the options.

First, my participation in the research database project will involve being asked, from time to time, to fill out questionnaires about my knowledge, perceptions and reactions to clinic trainings, policies and procedures. In addition, my participation involves allowing questionnaires that I complete about my clients (e.g., treatment alliance) and/or tapes from my sessions with clients to be placed into the database.

Please choose from the following options by placing your initials on the lines.

- I understand and agree that the following information will be included in the Research Database (check all that apply).
  - \_\_\_\_\_ Written questionnaires about my knowledge, perceptions and reactions to clinic trainings, policies and procedures
  - \_\_\_\_\_ Written Data about My Clients (e.g., Therapist Working Alliance Form)

\_\_\_\_\_ Video Data of sessions with my clients (i.e., DVD of sessions)

\_\_\_\_\_ Audio Data of sessions with my clients (i.e., CD or cassette tapes of sessions)

OR

- I do not wish to have any/all of the above information included in the Research Database.

\_\_\_\_\_

Please choose from the following options by placing your initials on the lines.

- I understand and agree that I may be contacted in the future about the opportunity to participate in other specific research programs at the GSEP Clinic or Counseling Center.

\_\_\_\_\_

OR

- I do not wish to be contacted in the future about the opportunity to participate in other specific research programs at the GSEP Clinic or Counseling Center.

\_\_\_\_\_

4. *My participation in the study will last until I leave my position at the GSEP Clinic or Counseling Center.*
5. I understand that there is no direct benefit from participation in this project, however, the benefits to the profession of psychology and marriage and family therapy may include improving knowledge about effective ways of training therapists and implementing policies and procedures as well as informing the field about how therapy and assessments are conducted in university training clinics.
6. I understand that there are certain risks and discomforts that might be associated with this research. These risks include potential embarrassment or discomfort at having faculty review materials about my clinic practices, which may be similar to feelings about supervisors reviewing my work ; however this risk is unlikely to occur since the written materials will be coded to protect your identity. Sensitive video data will be also coded to protect confidentiality, tightly secured (as explained below), and reviewed only by those researchers who sign strict confidentiality agreements.
7. I understand that I may choose not to participate in the research database project.
8. I understand that my participation is voluntary and that I may refuse to participate and/or withdraw my consent and discontinue participation in the research project at any time without prejudice to my employment in the GSEP Clinics and Counseling Centers. I also understand that there might be times that the investigators may find it necessary to end my study participation (e.g., if my client withdraws consent for participation in the research study).

9. I understand that the investigators will take all reasonable measures to protect the confidentiality of my records and my identity will not be revealed in any publication that may result from this project.
10. The confidentiality of my records will be maintained in accordance with applicable state and federal laws. Under California law, there are exceptions to confidentiality, including suspicion that a child, elder, or dependent adult is being abused, or if an individual discloses an intent to harm him/herself or others. I understand there is a possibility that information I have provided regarding provision of clinical services to my clients, including identifying information, may be inspected and/or photocopied by officials of the Food and Drug Administration or other federal or state government agencies during the ordinary course of carrying out their functions. If I participate in a sponsored research project, a representative of the sponsor may inspect my research records.
11. The data placed in the database will be stored in locked file cabinets and password-protected computers to which only the investigators, research team members and clinic directors will have access. In addition, the information gathered may be made available to other investigators with whom the investigator collaborates in future research and who agree to sign a confidentiality agreement. If such collaboration occurs, the data will be released without any personally identifying information so that I cannot be identified, and the use of the data will be supervised by the investigators. The data will be maintained in a secure manner for an indefinite period of time for research purposes. After the completion of the project, the data will be destroyed.
12. I understand I will receive no compensation, financial or otherwise, for participating in study.
13. I understand that the investigators are willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Dr. Kathleen Eldridge at (310) 506-8559, Dr. Mesha Ellis at (310) 568-5768, or Dr. Susan Hall at (310) 506-8556 if I have other questions or concerns about this research. If I have questions about my rights as a research participant, I understand that I can contact the Chairperson of the Graduate and Professional Schools IRB, Pepperdine University at (310) 568-5600.
14. I will be informed of any significant new findings developed during the course of my participation in this research which may have a bearing on my willingness to continue in the study.
15. I understand to my satisfaction the information regarding participation in the research project. All my questions have been answered to my satisfaction. I have received a copy of this informed consent form which I have read and understand. I hereby consent to participate in the research described above.



---

Participant's signature

---

Date

---

Participant's name (printed)

I have explained and defined in detail the research procedure in which the participant has consented to participate. Having explained this and answered any questions, I am cosigning this form and accepting this person's consent.

---

Researcher/Assistant signature

---

Date

---

Researcher/Assistant name (printed)

## APPENDIX C

### Change and Growth Experiences Scale Training Manual

#### **CHANGE AND GROWTH EXPERIENCES SCALE TRAINING MANUAL**

(adapted from CHANGE, Hayes & Feldman, 2005)

This training manual is intended to help orient you to the methods of transcription and coding that will be utilized for the research projects. The specific therapy tapes will be clients and therapists at the Pepperdine University clinics that have been selected by Dr. Hall based on inclusion/exclusion criteria (e.g., individual adult clients representing diverse ethnicities, genders, religions, and presenting issues). Josina Grassi Moak, Stacie Cooper, and Alexander Bacher will be utilizing this for their respective dissertations to gain a more in-depth understanding of how clients talk about coping, hope, and meaning-making early in therapy (first few sessions). Your role as research assistants will be to transcribe the sessions in great detail and help with the preliminary coding phase for each of the constructs measured by CHANGE (see below).

#### I. TRANSCRIPTION INSTRUCTIONS

(adapted from Baylor University's Institute for Oral History -  
[http://www3.baylor.edu/Oral\\_History/Styleguiderev.htm](http://www3.baylor.edu/Oral_History/Styleguiderev.htm) )

The first step will be to transcribe verbatim each therapy session to be included in the research to provide a format for more in-depth analysis of client statements to then be coded using the CHANGE codes listed below (for meaning-making, hope, and coping). Attached at the end of this section is a template that you will use for your transcriptions. After reading this manual and discussing questions during training, you will be asked to practice transcribing an excerpt from a Motivational Interviewing tape by William Miller. At the end of the manual, you will find a completed transcript to use to check your work.

A good transcription should reflect as closely as possible the actual words, speech patterns, and thought patterns of the speakers. The speakers' word choice, including his/her grammar and speech patterns should be accurately represented. The transcriber's most important task is to render as close a replica to the actual event as possible. Accuracy, not speed, is the transcriber's goal.

When identifying who is speaking, use a "T" to indicate the therapist is speaking and a "C" to indicate the client is speaking. In addition, please use numbers to indicate how many times each person is speaking. For example, the first the therapist speaks represent it as T1: and the second time as T2, T3, etc., and vice versa for the client (C1, C2, C3, etc.)

Long passages should be broken into new paragraphs to enhance readability. If one of the speakers speaks for a long time, or includes multiple different ideas/thoughts in a given response, please break the long response up into shorter segments by topic/idea and represent each different topic/idea by starting new paragraph, indenting two spaces, and using the following numbering system:

C12: .....  
 C12.1: .....  
 C12.2: .....  
 C12.3: .....  
 T13: .....  
 C14: .....

In addition to capturing the actual words, speech patterns and thought patterns of the speakers, we would like to try and capture some of the more important non-verbal behaviors/communication taking place between the therapist and client. In order to do so, please use parentheses with numbers inside of them to indicate pauses in a speaker's response. For example, use (3) to represent a three second pause or (10) for a ten second pause. Use this whenever there are significant pauses or moments of silence between the speakers.

When attempting to capture non-verbal behaviors/movements that are significant to the therapeutic interaction taking place, use brackets [ ] to indicate these movements and clearly state which person—the therapist or client—is performing the movement and what specifically he/she does. For example, [Client turned away from the therapist and looked down at the ground] or [Client laughs] or [Therapist sighed deeply and looked away briefly]. Also use brackets to indicate the inability to hear/understand a word or sentence: [Unintelligible] or [Inaudible]. Please make every effort to hear and understand what is said. Sometimes you can figure out a word by the context of what the speaker is saying. If you can make an educated guess, type the closest possible approximation of what you hear, underline the questionable portion, and add two question marks in parentheses.

Example: I went to school in Maryville (??) or Maryfield (??).

If you and those you consult cannot make a guess as to what is said, leave a blank line and two question marks in parentheses.

Example: We'd take our cotton to Mr. \_\_\_\_\_(??)'s gin in Cameron.

If a speaker lowers his/her voice, turns away from the microphone, or speaks over another person, it may be necessary to declare that portion of tape unintelligible.

Example: When he'd say that, we'd— [unintelligible].

While there is some merit in having an absolutely verbatim tape, which includes all the feedbacks (such as Um-hm and Yeah), too many interruptions in the flow of the interviewer's remarks make for tedious transcribing now and exhaustive reading later. Knowing when to include feedback sounds and when to omit them calls for very careful judgment. Usually the interviewer's noises are intended to encourage the interviewee to keep talking. Look at your transcript. If every other line or so is an interviewer's feedback, go back and carefully evaluate the merit of each feedback. Don't include every feedback, especially if it interrupts the interviewee's comments in midstream. Only if the feedback is a definite response to a point being made by the interviewee should you include it. When in doubt, ask.

Type no more than two crutch words per occurrence. Crutch words are words, syllables, or phrases of interjection designating hesitation and characteristically used instead of pauses to allow thinking time from the speaker. They also may be used to elicit supportive feedback or simple response from the listener, such as: you know, see?, or understand?

Use of *Uh*: The most common word used as a crutch word is *uh*. When *uh* is used by the narrator as a stalling device or a significant pause, then type *uh*. But sometimes a person will repeatedly enunciate words ending with the hard consonants with an added "uh," as in and-uh, at-uh, did-uh, that-uh, in-uh. Other examples are to-uh, of-uh, they-uh. In these instances, do not type *uh*.

Guggles are words or syllables used to interrupt, foreshorten, or end responses, and also as sounds of encouragement. Guggles are short sounds, often staccato, uttered by the interviewer to signal his desire to communicate. They may be initial syllables of words or merely *oh*, *uh*, *ah*, or *er*. Spelling of specific guggles: Agreement or affirmation: uh-huh, um-hm; Disagreement: unh-uh.

For consistency, use only the following for exclamations:

- Uh
- Um
- Uh-huh
- Mm-hmm
- Unh-uh

Do not use ah, oh, er, and so forth. Pick from the list above and use what seems closest to what is being uttered.

Incomplete sentences are familiar occurrences in oral history because of its conversational nature. They are best ended with an em dash (—).

Quotation Marks:

1. When a direct expression is spoken by one person (I, he, she), set apart the expression with commas, use opening and closing quotation marks, and capitalize the first letter of the first word quoted. Example: She said, "I am going to graduate in May."
2. When a direct expression is spoken by more than one person (we, they), do not use quotation marks, but do set apart the expression with commas and do capitalize the first letter of the first word quoted. Example: They said, What are you doing here?
3. When a thought is quoted, do not use quotation marks, but do set the thought apart by commas and capitalize the first letter of the first word quoted. Example: I thought, Where am I?

When finished transcribing, please go through the session one last time to make sure you have captured all the spoken data and as many of the important non-verbal behaviors as possible.

#### TRANSCRIPTION TEMPLATE

### CONFIDENTIAL VERBATIM TRANSCRIPT

**Confidentiality:** The following is a confidential document, which may contain information that could be detrimental if used by untrained individuals. Nonconsensual disclosure by individuals not associated with Pepperdine University and the Positive Psychology PARC lab is prohibited.

Session Number:  
Client #:

Coder:  
Date of Session:

C = Client  
T = Therapist

Verbatim Transcript of Session	Initial Coding Impressions
T1:	
C1:	
T2 :	
C2:	
T3:	

C3:	
T4:	
C4:	
T5:	
C5:	

## II. CODING OVERVIEW

This coding system is designed to study the variables associated with change in therapy or in adaptation to life events. There are two parts to the CHANGE, a measure of client or participant variables and a measure of therapist interventions. We will focus on the client variables in our study.

**CHANGE Client Variables** can be used to code essays or therapy sessions. We will be using it to code transcripts of therapy sessions that clients and therapists have consented to place in a confidential research database. The coding system assesses seven content areas and three client processes. For the purposes of our studies, these areas will be covered in the manual:

- 1) Sense of hope
- 2) Historical antecedents
- 3) Relationship Quality
- 4) Protection/avoidance
- 5) Cognitive/emotional processing
- 6) Unproductive processing

### 1. Coding Steps:

1. **Read this manual and learn the CHANGE codes**
2. **Watch the video tape of session all of the way through, take notes in the right hand column of the transcript to get a general gist of possible applicable codes, impressions of client (non-verbals versus language, tone, affect, etc.)**
3. **Read the transcript all the way through to gain an overall sense of the client in this session. Again, take notes.**

The notes will help you to remember the reasons for your coding decisions and will help you in the discussions in the consensus meetings.

4. **Read the transcript again in detail by looking at each statement (C1, C2, etc.) and write your coding impressions on the code sheet.**
5. **Review your code sheet and give your final ratings.**

When coding, you want to **try to balance attention to details with an ability to think abstractly** and see the bigger picture. It is also important to maintain focus by pacing yourself carefully. It is difficult to code accurately when you are rushed or code in binges. In the discussion meetings, it helps to present your questions and confusions and to agree with others only when the consensus makes sense. Coding requires an **openness and flexibility but not acquiescence**.

Record each instance in the transcript that you believe a code is present on the code sheet (record “C1,” “C2” etc. and the phrase you believe matches the code). Then, tally the frequency count on the code sheet. This will help to verify your overall score and will be used during group meetings to discuss and compare scores for the sessions. Refer to training materials when guidance is needed.

Next, rate each category using the appropriate scale. Some ask you to rate intensity during the session. This is done by giving a rating from **0** to **3**:

#### **INTENSITY**

**0 = NONE (0-1 ratings for session)**

**1 = LOW (2 or more; rarely, a bit, minimal, infrequently, now and then)**

**2 = MEDIUM (sometimes, kind of, variable, reflecting ambivalence)**

**3 = HIGH (almost always, very much, all of the time, really, incredibly)**

Other categories ask you to rate valence (**positive or negative**) or (“**absent**” or “**present**”). For example, if you believe that a client statement depicts perceived POSITIVE RELATIONSHIP QUALITY, you would mark “positive relationship quality.”

Please make sure that all of the categories for each essay or session are completed. Note that the **coding categories are not mutually exclusive**, which means that categories overlap and can co-occur. For instance, there can be both positive and negative emotion in the same essay or session. The categories of emotion and somatic functioning often overlap.

When coding a therapy session, **consider the context** provided by the therapist and client. At times, the person will refer loosely to previous content. For instance, a person might talk about past failures and feelings of incompetence and then in subsequent essays or sessions say, “I screwed up again. Here we go again, I feel horrible.” The terms, “screwed up again” and “here we go again” refer back to the more explicitly articulated negative view of the self and cycle of self-criticism from previous essays or sessions.

In using context, consider the person’s baseline but also use a standard scale so that comparisons can be made across individuals. For instance, when coding the material from someone who is depressed, the emotional tone is often consistently negative. In this context, a glimmer of positive emotion can appear to warrant a high rating, when it should actually be coded as low. Similarly, in the context of a destructive relationship, a mildly positive event can seem to warrant a high positive emotion rating because the baseline is so low. Be careful of this **baseline bias**.

Mark each phrase or verbalization for which you are unsure of the coding to bring up in the next team meeting for review. If you find a given section or category particularly difficult to code, make note of the issues and what went into your decision. The coding meeting might be a week after you’ve coded the passage, and this will help you to remember your thought process.

## **2. SPECIFIC CODES USED FOR THIS STUDY:**

### **A. CONTENT CODES**

#### **1) SENSE OF HOPE (AGENCY) (CHANGE SCALE)**

This code captures the person’s capacity to see the possibility of *change in the future, to recognize recent positive changes (1month in past at most)*, and to express a commitment or determination to make changes. You will be coding the intensity (0-3) of negative and positive hope.

\* Client has to verbally express feelings of agency, motivation, commitment, determination and their role in it.

Negative: a feeling of being stuck, trapped, having no way out, sinking, feeling tired of trying, or a lack of commitment. Sometimes one can experience a giving up of old ways before change.

Although this is **hopelessness** before change, it is still coded as negative hope

*Examples:*

- “I hate my life. I feel stuck. I can’t see a way out.” (NEGATIVE, HIGH)
- “**Sometimes** (or often) I feel stuck or get tired of the games” (NEGATIVE, MEDIUM)
- “**Every once in a while** I just get tired of the games.” (NEGATIVE, LOW)

Positive: a feeling of movement and possibility, a motivation, commitment or determination to change

*Examples:*

- “I am realizing that **I do have some control** over my mood and fate.” (POSITIVE, HIGH)
- “I have got to stop beating myself up. I must stop.” (POSITIVE, HIGH)
- “At present time, I am energetically pursuing my goals.” (POSITIVE HIGH)
- “Right now, I see myself as being pretty successful.” = (POSITIVE HIGH)
- “At this time, I am meeting goals I have set for myself.” = (POSITIVE HIGH)
- “Currently, I believe I MAY be able to change my problems.” = (POSITIVE MEDIUM)
- “I kind of feel ready for a fresh new start.” = (POSITIVE, MEDIUM)
- “**I sometimes** feel like I am **capable** of changing.” (POSITIVE, MEDIUM)
- “I sometimes think I can get out of my depression but I am not sure today.” = (POSITIVE LOW)
- “I am **beginning to think** that there **might** be a way out of this mess.” (POSITIVE, LOW)

#### **ALTERNATE HOPE CODE: SNYDER’S HOPE CONSTRUCT (PATHWAYS)**

Brief overview: C.R. Snyder’s emotive/cognitive hope theory is currently the most widely used and researched model of the hope construct in clinical psychology. Snyder conceptualized hope as a combination of an individual’s personal goals, motivation (agency) and his or her perceived pathways to achieve those goals. He has developed measures that look at current hopeful thinking about general life goals including agency and pathways items, which have been modified and included to compare this definition of hope to the CHANGE construct above.

#### **PATHWAYS**

This involves goal-directed thinking (cognitive process of brainstorming options for self) in which the individual perceives that he or she can produce ROUTES, STRATEGIES, to move toward the direction of desired goals, or **planning ways to meet goals, and specific behaviors to perform toward the goal; steps in the right direction.**

**In other words: brainstorming options, possible routes toward goals: “Here is how I can do it”**

For PATHWAYS, the PRESENT OR FUTURE goals must be perceived by the person to be **possible, and desirable- manageable goals that can be realistically achieved.**

**Pathways is only marked on *intensity*, not positive or negative (note or check specific examples of each and rate overall code based on specific examples and number of statements made- e.g., if the session contains 5 high pathways statements and 2 medium, it would be high pathways overall).**

*Examples:*

- “If I should find myself stuck or in a jam, I could think of many ways to get out of it.” = HIGH PATHWAYS (multiple and/or specific ways – one is okay with elaboration and certainty)
- “There are lots of ways around any problem I am facing right now.” = HIGH PATHWAYS
- “I can think of ways to meet my current goals.” = HIGH PATHWAYS
- “I could look for other jobs, or maybe I will tell my boss how I feel and that will make things better at work.” = HIGH PATHWAYS
- “Couples therapy is a way for me to figure out if this relationship is worth saving.” =HIGH PATHWAYS
- “There might be some ways out of my abusive relationship that I can try.” = MEDIUM

- PATHWAYS (one specific, or multiple uncertainty)
- “I think that going to couples therapy might be a way that I can figure out if this relationship is worth saving.” = MEDIUM PATHWAYS
- “I can maybe see a realistic way to improve my mood but I am not sure.” = LOW PATHWAYS (non-specific and uncertainty)

**Coders may also be asked to indicate on the coding sheet the types of pathways they noticed during the session.**

## **2) HISTORICAL ANTECEDENTS (EARLY CAREGIVERS)**

This category captures the extent to which the person focuses on early experiences with parents or early caretakers when identifying, exploring, or examining issues related to current problems. Higher scores reflect a) a more elaborated discussion of historical antecedents, and b) a discussion that integrates past experiences with current problems or with positive changes.

*Examples:*

Negative	High Negative: <ul style="list-style-type: none"> <li>• “My mother taught us that it was best to ‘never air dirty laundry.’ It was forbidden to go outside the family when there was a problem. No wonder it is so hard for me to ask for help when I need it.”</li> </ul>
	Medium Negative:
	Low Negative: <ul style="list-style-type: none"> <li>• “My parents were cold and critical.” (The client does not elaborate on this comment or connect it with current issues. This has the potential to be rated as high, but there is not enough content provided.)</li> </ul>
Positive	High Positive: <ul style="list-style-type: none"> <li>• “You know, my father always believed in me. Although I have periods of self-doubt, his words always come through when I am down. He used to tell me that I was a strong character and that I could get through most of what life has to give me. I try to remember that when I feel anxious.”</li> <li>• “I am starting to realize how important my grandmother was. When my parents were drinking and having all kinds of problems, she was a stable force. She keeps me from getting really depressed at times.”</li> </ul>
	Medium Positive:
	Low Positive: <ul style="list-style-type: none"> <li>• “As I think about why I am so nervous around people, I am puzzled because I never had anything horrible happen, and my parents were supportive.” (This is a low positive because it is not elaborated on)</li> </ul>

### **ADDITIONAL CODE: ALL HISTORICAL ANTECEDENTS (not limited to caregivers):**

This is an additional code to account for the limitations of CHANGE that only measures the individual’s mention of experiences with early caregivers or parents and how those affect their experiences, problems, etc. This additional code will function exactly the same way as the other Historical Antecedents code, but also take into account important/significant experiences with people other than parents/caregivers in the individual’s life. E.g. Friends, partners, relatives, etc. In addition, any significant past precipitating events related to current problems or positive changes that has had some definitive ending point in the past (at least a month ago, and not ongoing. **Past events** or experiences. “It reminds me of...” OR “that relates kind of to when...”

*Examples:*

Negative	High Negative: <ul style="list-style-type: none"> <li>• “I started feeling anxious when I moved to LA because there is so much</li> </ul>
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	pressure to conform and fit in, which made me focus on my flaws and feel anxious.”
	Medium Negative: <ul style="list-style-type: none"> <li>• “I started feeling anxious when I moved to LA.”</li> </ul>
	Low Negative: <ul style="list-style-type: none"> <li>• “LA is a harsh place to grow up.”</li> </ul>
Positive	High Positive: <ul style="list-style-type: none"> <li>• “I always had a strong connection to my church growing up, which helped provide a strong support system and foundation for belief in myself and I try to turn to god when I am feeling down and believe things happen for a reason.”</li> </ul>
	Medium Positive: <ul style="list-style-type: none"> <li>• “I always had a lot of support growing up in New York with my friends and these friends help me get through ups and downs.”</li> </ul>
	Low Positive: <ul style="list-style-type: none"> <li>• “It was easy to make friends growing up in New York.”</li> </ul>

**Coders may also be asked to indicate on the coding sheet the types of historical antecedents they noticed during the session.**

### 3) **FEELINGS TOWARD RELATIONSHIP QUALITY**

This category captures the perceived quality of the person’s interactions with others that week or in general. This can involve immediate family, romantic partners, friends, co-workers, or people in general. This is not a frequency count like the behavior category, but rather how positive or negative the person *perceives* the interactions to be (as interpreted by overall session statements). This can include memories about past relationships or fears about future relationships, if the memories or fears are tied to current functioning. This **does not need to include direct *feeling* statements. The words chosen assumed to reflect feeling-attend to the STRENGTH of positive or negative descriptive words when coding.**

Negative: Encounters that involve distress or dissatisfaction, such as feeling slighted, ignored, alienated, humiliated, controlled, manipulated, betrayed, or engaging in conflict. Feelings of alienation, isolation, and loneliness can also be activated in the absence of encounters.

Positive: Encounters that involve enjoyment or satisfaction, such as feeling part of a group, cared for, loved, connected, or stimulated.

*Examples:*

- “I went to see my family for my father’s birthday, but the criticism began in the first hour. I felt myself shut down, just like I did when I was a child.” (NEGATIVE, HIGH)
- “I felt left out of a party at work last weekend. Roberto slipped and mentioned the party. When he realized that I hadn’t been invited, he stuttered and tried to make excuses. Why did they exclude me? Why doesn’t anyone want to be with me? I don’t understand.” (NEGATIVE, HIGH)
- \* “She was so bitchy to me and she and the girls at work are always catty and talk shit.” (NEGATIVE, HIGH)
  - “Sometimes I think I will never have a good relationship, so why bother. A lot of times I wonder if the person I am dating now will leave me...” (NEGATIVE, MEDIUM; This is an example of a fear or hypothetical outcome.)
  - “I have had a couple of days where I feel alone, but then I call my friends and feel more connected.” (NEGATIVE, LOW)

*Examples:*

- “I went home and had a heart-to-heart talk with my husband about wanting to spend more time together. He suggested that we take a vacation together, and I felt like he cared. It really felt good.” (POSITIVE, HIGH)

- “And I think my supervisors were trying to make me feel comfortable and let me know I had their undying support and this created a welcoming atmosphere to transition back to work.” (POSITIVE, MEDIUM) – some positive statements said with less certainty, or coder not able to distinguish certainty
- “Things are on and off with my mother, sometimes I think she is helpful and supportive and sometimes I feel like she doesn’t get me.” (POSITIVE, MEDIUM)
- “I made myself go to an ALANON meeting. It was OK, I guess. I hope it helps.” (POSITIVE, LOW)

**Coders may also be asked to indicate on the coding sheet the types of relationships they noticed during the session.**

## B. PROCESS CODES

### INSTRUCTIONS

Rate the extent to which the person reports the following reactions in the essay or session. The categories in this section are not coded for valence (positive, negative) but are coded as low, medium, or high. **Attend to entire session when coding process codes-**

#### 1) COGNITIVE/EMOTIONAL PROCESSING

This category captures the extent to which the person approaches a problem and explores, tries to understand, challenge, and make meaning of it. It can begin as thinking about and questioning a problem area or exposing oneself to new information, and then is followed by insight or shift in perspective or meaning. The ratings of low, medium and high reflect **level** of processing, rather than frequency or intensity. **NOTE: Coders should attend to the context of the entire session**, noting patterns of approaching a problem or pattern of processing. If pattern is repetitive or there seems to be no resolution by end of session, consider repetitive processing code. At medium and high levels, there are often emotional or behavioral manifestations of this shift in perspective/meaning.

Inquisitive, wondering rather than describing.

**Cognitive/emotional processing usually takes place in narrative form, in which people use reappraisal, reattribution, and other revaluing techniques in order to better understand/make sense of some experience/aspect of their lives which is presently causing them distress. This is done in order to help realign their situational meaning (problematic experience/feelings) with their global meaning (people’s enduring beliefs, values, goals, assumptions and expectations about the world) and relieve any anxiety/despair associated with the incongruence.**

*Examples:*

0 = N/A	No processing is apparent or slight movement toward thinking about or approaching a problem
1 = Low	Exploring and questioning a problem area, but without a significant insight and uncertainty: <ul style="list-style-type: none"> <li>• “Looking back now, I think maybe my co-workers were so unpleasant toward me because they were envious of me...”</li> <li>• “I began to wonder why I had stayed so long in this unhealthy relationship. What kept me there? What was I getting out of it?”</li> <li>• “I think some of it might be due to my fear of intimacy, but I’m not sure.”</li> <li>• “I wonder why I am so scared of succeeding. Why do I avoid the spotlight?”</li> </ul>
2 = Medium	Exploring and questioning a problem area with some new connections and insights and more certainty, but no substantial perspective shifts: <ul style="list-style-type: none"> <li>• “I realized that I am afraid to succeed. I have been holding myself back because I am afraid to move too fast and then to fail.”</li> <li>• “I made myself go to three meetings this week, and my anxiety decreased a little bit. I’ll keep working on my exposure exercises.”</li> </ul>

	<ul style="list-style-type: none"> <li>• “After talking about his death over and over with my therapist, it is beginning to be less painful.”</li> </ul>
3 = High	<p>Engaged and exploring or confronting a problem area with substantial insight and perspective shifts—an “Ah-ha” like experience-physiological affective reaction. This can include making new meaning of experience, <b>integrating past experience with current functioning</b>, benefit finding, reframing, reaching a higher level of abstraction, and resolutions/acceptance:</p> <ul style="list-style-type: none"> <li>• “Then it hit me, I must stop running. I run and run so that I won’t get hurt, but then I can’t feel at all, and I am alone. I am exhausted. I want to feel again, connect with other people, and live again.”</li> <li>• “I feel more solid. Bad things still come my way, but somehow I don’t let things devastate me as I did before. I am starting to see that the bad things are not personal; they are part of being alive.”</li> <li>• “My mother was a jerk to me when I was younger, but I realize that she thought she was protecting me from living a life that she did. In doing so, she killed my spirit and made me afraid of my own shadow. Somehow by pushing it this far, something in me snapped. I finally protected and took care of myself.”</li> </ul>

## 2) UNPRODUCTIVE (REPETITIVE) PROCESSING

This category captures the extent to which the person approaches a problem, explores, tries to understand, and make meaning of it, BUT gets stuck **repetitively** thinking about or analyzing a problem without significant insight. Unproductive processing can occur not only in a session or essay, but also across time; therefore it is important to consider the context.

*Examples:*

0 = N/A	No or little evidence of being stuck
1 = Low	<p>Exploring and questioning a problem with <b>some</b> evidence of repetitive or intrusive thoughts or repetitive venting of emotion with little or no insight:</p> <ul style="list-style-type: none"> <li>• “I began to wonder why I had stayed so long in this unhealthy relationship. I think about him a lot, and I get mad at myself. I feel like I’m not getting anywhere.”</li> </ul>
2 = Medium	<p>Exploring and questioning a problem area with <b>clear</b> evidence of repetitive thoughts and emotions with little or no insight. The repetition is not as frequent or as elaborated as at the high level:</p> <ul style="list-style-type: none"> <li>• “I realized that I am afraid to succeed. Why am I so afraid? What is wrong with me? Why can’t I be normal? I’m so sick of myself.”</li> </ul>
3 = High	<p>Strong evidence of repetitive thoughts and emotions. These can involve rumination, perseveration, obsessions, repetitive intrusive thoughts, and difficulty disengaging from emotions. There is usually evidence of vicious cycles and of being caught in a cognitive/emotional loop:</p> <ul style="list-style-type: none"> <li>• “I can’t stop thinking about everything that I did to hurt him and how I have failed in relationships. I’ve failed at everything. I am haunted by a list of failures.”</li> <li>• “I have to quit putting these sad records on. I hear the sad music and start the pity party. On and on it goes...”</li> </ul>

### **3) PROTECTION/AVOIDANCE**

This category captures attempts to protect or defend oneself by pulling away from rather than moving toward problems or issues. Pulling away can take many forms, such as social withdrawal, staying in bed, numbing, mentally avoiding certain topics, substance use for coping, distraction, difficulty concentrating and focusing, wandering off topic/topic change, using humor to avoid the topic, minimizing, blaming others or external circumstances. Some other words associated with this category are “disengaged, disconnected, unplugged, sleepwalking through life, numbed or tranced out.”

Externalization of problems, and in session behaviors: lots of shrugging, “I don’t know,” not answering, or “I don’t want to talk about that.”

*Examples:*

#### **HIGH PROTECTION/ AVOIDANCE**

- “I can’t believe she did this to me. It’s all her fault. She keeps trying to pull me into this, but our relationship could have worked, if she weren’t so difficult.”(Person blames the other and spends all of the time focusing on her problems)
- After a difficult session or essay, the person reports, “I have been out of it this week. I’m in a fog and feel totally numb and shut down.” (Person shuts down after an intense session)
- Above-mentioned behaviors/statements exhibited for at least two thirds of the session or for most of the period of time discussed in the session.

#### **MEDIUM PROTECTION/ AVOIDANCE**

- “He never helps me like he doesn’t care. I know that I also have a part in it but I just didn’t want to bring it up with him. (Blames others and focuses on others problems, but can elaborate some of own avoidance)
- Moderate amount of minimizing in session, discounting statements changing topics or discussing avoidance behaviors such as substance use or withdrawal behaviors for at least half of the session.

#### **LOW PROTECTION/ AVOIDANCE**

- “I was feeling kind of anxious, so I didn’t feel like going out this week.” (Person mentions some avoidance, but it is not elaborated enough to score medium or high).
- Some behaviors or topics mentioned above, but occur in less than one third of session.

Finally, when you have finished tallying your best guesses for frequencies and overall scores, make sure you put your name, session number, client ID number, and bring for team meetings to discuss/compare findings. Good luck and have fun!



## APPENDIX D

## Change and Growth Experiences Scale Coding Worksheet

Record intensity next to each specific statement (L, M. or H; and P or N)

Example: C2.1: “Client paraphrased statement”- L P Hope would be low positive hope for client statement 2.1 from transcript

INTENSITY: 0 = NONE (0-1 ratings for session)

1=LOW (2 + ratings for session: rarely, a bit, minimal, infrequently, now and then)

2 = MEDIUM (sometimes, kind of, variable, reflecting ambivalence)

3 = HIGH (almost always, very much, all of the time, really, incredibly)

	<i>Examples from each session (notes and line number from transcript)</i>	<i>Frequency of occurrence</i>	<i>Intensity = None (0), Low (1), Med (2), High (3)</i> <i>Total session score = overall code</i>
	<b>Sense of Hope</b>		<b>Overall Code:</b>
<b>Positive “I can do it”</b>		Low: Medium: High:	Feeling of movement, expectancy and possibility that one can make improvements in one’s life in recent past (within 1 month or less), present, or future.  Perception of one’s capacity to initiate and sustain movement towards very recent, present or future goals.  Commitment, motivation, belief in ability, determination to change.
<b>Negative</b>			<b>Overall Code:</b>
		Low: Medium: High:	Feeling of being stuck, trapped, having no way out, sinking, hopeless.  Feeling tired of trying or lack of commitment.
<b>Pathways “Here is how I can do it”</b>	<b>Snyder’s Additional Hope Code</b>		<b>Overall Code:</b>
		Low: Medium: High:	Cognitive processes involving brainstorming, specific ways to achieve or move toward goals, looking for, finding, exploring ways to move forward.  Specific behaviors or steps in the right direction, identifying or planning actions to meet goals
	<b>Relationship Quality (Perceptions Expressed)</b>		<b>Overall Code:</b>
<b>Positive</b>		Low: Medium:	Perceived quality of interactions with others that week or in general.

		High:	Encounters that involve enjoyment or satisfaction, such as feeling part of a group, cared for, loved, connected, stimulated
<b>Negative</b>		Low: Medium: High:	Encounters that involve distress or dissatisfaction, such as feeling slighted, ignored, alienated, humiliated, controlled, manipulated, betrayed, or engaging in conflict.  Feelings of alienation, isolation, and loneliness can also be activated in the absence of encounters
	<b>Cognitive Emotional Processing</b>		<b>Overall Code:</b>
		Low: Medium: High:	Engaged, exploring, or confronting problem areas, making new meaning out of experiences, integrating past experiences with current functioning in a new way.  Reframing, benefit-finding, acceptance, resolutions- present “Ah-hah” moments of new insight. It can begin as thinking about and questioning a problem area or exposing oneself to new information.
	<b>Unproductive (Repetitive) Processing</b>		<b>Overall Code:</b>
			Explores problems, tries to understand, make meaning, but keeps getting stuck.  Repetitive thinking about problem without insight, perseveration, obsessions, rumination, repetitive emotions surrounding problem.  Analyzing a problem without significant insight.
	<b>Protection/Avoidance</b>		<b>Overall Code:</b>
		Low: Medium: High:	Moving away from problems, protecting, defending oneself through avoiding topics, numbing, substance use for coping, using humor to avoid topics.  Minimizing or blaming others or external circumstances, disconnected, in a trance, disengaged. Distraction, difficulty concentrating and focusing, wandering off topic, changing topic, silence, “I don’t know” statements...  Pulling away can also take many forms, such as social withdrawal, staying in bed, and numbing.